



# Coverage Policy Manual

**Policy #: 2026001**

**Preventive Services**

**Version 1.2 / Effective 05/01/2026**

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## DESCRIPTION

The Federal Patient Protection and Preventive Care Act (PPACA) was passed by Congress and signed into law by the President in March 2010. The preventive services component of the law became effective September 23, 2010. A component of the law was a requirement that all “non-grandfathered” health insurance plans are required to cover those preventive medicine services given an “A” or “B” recommendation by the U.S. Preventive Services Task Force (USPSTF). Additionally, the law requires coverage of Bright Futures recommendations for children from the American Academy of Pediatrics, preventive services for women outlined by the Health Resources and Services Administration’s (HRSA’s) Women’s Preventive Services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), adopted by the Centers for Disease Control and Prevention (CDC), for routine use for a given individual.

Plans are not required to provide coverage for the preventive services if they are delivered by out-of-network providers.

USPSTF recommendations are graded on a five-point scale (A-E), reflecting the strength of evidence in support of the intervention. Grade A: There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination. Grade B: There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination. Grade C: There is insufficient evidence to recommend for or against the inclusion of the condition in a periodic health examination, but recommendations may be made on other grounds. Grade D: There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination. Grade E: There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

Those preventive medicine services under Section I of this policy listed as Grade A & B recommendations as well as HRSA recommended preventive care and screenings for infants, children, adolescents and women are covered without cost sharing (i.e., deductible, co-insurance, or co-pay) by Health Plans for appropriate preventive care services provided by an in-network provider. If the primary purpose for the office visit is for other than one of these recommended preventive care services, a deductible, co-insurance, or copay may be applied.

Services are typically included as part of a normal wellness visit; the appropriate office visit code should be used. Evaluation and Management codes for preventive services 99381-99397 will always be considered preventive. CPT Codes 99401-99404, when used to designate a preventive service, must have the applicable wellness/preventive diagnosis code as the primary reason for the visit.

Note: (99401-99404 are considered components of 99386-99387 if billed on the same date-of-service.)

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with Modifier -33’.

The correct coding as listed for both ICD 10 and CPT or HCPCS codes is also required along with Modifier 33.

### **For Self-funded plans with SPD language**

Certain self-funded plans may have a different list of preventive care benefits. Please refer to the enrollee's plan specific SPD for coverage. Group specific policy will supersede this policy when applicable. **This policy does not apply to the Wal-Mart Associates Group Health Plan participants.**

## **I. PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS**

The services in this section are covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) as mandated by the Federal Patient Protection and Preventive Care Act (PPACA) passed by Congress and signed into law by the President in March 2010.

### **ABDOMINAL AORTIC ANEURYSM, SCREENING (Measure 1)**

Screening for abdominal aortic aneurysm by ultrasonography is covered for members of “non-grandfathered” plans on a one-time basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay) in men 65 to 75 who have ever smoked.

#### **USPSTF Recommendation (Released Feb 2005; Effective on or after Sep 2010) (Re-released Dec 2019)**

The USPSTF recommends one -time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked (Grade B)

#### **CPT/HCPS Codes**

CPT 76706 - Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)

#### **ICD-10 Codes**

Z87.891 – Personal history of nicotine use,  
Z13.6 – Encounter for screening for cardiovascular disorders

#### **Frequency**

Once per lifetime for men ages 65 – 75

### **ALCOHOL AND DRUG MISUSE COUNSELING AND/OR SCREENING (Measure 2)**

Screening for unhealthy drug use, using risk screening questions, for adults aged 18 years or older in primary care settings is covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) once per year. Screening refers to asking questions about unhealthy drug use, **not** testing biological specimens. (Effective November 1, 2020)

Screening and behavioral counseling interventions to reduce alcohol misuse in adults aged 18 years or older, including pregnant women, in primary care settings are covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) once per year.

**USPSTF Recommendation (Released Apr 2004; Effective on or after Sep 2010) (Update and Re -Released November 2018)**

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. (Grade B)

**USPSTF Recommendation (Released June 2020)**

The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Grade B)

(Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

**CPT/HCPCS Codes**

CPT 99408 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15-30 minutes

CPT 99409 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), And brief intervention (SBI) services; greater than 30 minutes

HCPCS G0442 – Annual alcohol misuse screening, 15 minutes

HCPCS G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

**ICD-10 Codes**

F10.10 – Non-dependent alcohol abuse

F10.120 – Non-dependent alcohol abuse

F10.129 – Non-dependent alcohol abuse

Z71.41 – Alcohol abuse counseling

Z00.00 – Encounter for general adult medical examination without abnormal findings

Z00.01 – Encounter for general adult medical examination with abnormal findings

**Frequency**

Annual screening for all adults, 15 – 30 minutes

Annual counseling for all adults who screen positive for alcohol misuse

### **ALCOHOL AND DRUG USE SCREENING FOR ADOLESCENTS BEGINNING AT AGE 11 -21 (Measure 2)**

Screening for alcohol or drug use using risk screening questions is covered as part of the preventive health exam, and administration of alcohol and drug screening tools to those who test positive to the risk screening questions are covered for adolescents who are covered under "non-grandfathered" plans, without cost sharing (i.e., deductible, co-insurance, or co-pay) during the preventive health exam between the ages of 11-21.

#### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Bright Futures recommends initiating questioning regarding alcohol or drug use and if positive, to follow with an alcohol or drug screening tool for children and adolescents, ages 11 -21.

#### **CPT/HCPCS Codes**

CPT 99408 – Alcohol and/or substance (other than tobacco) abuse structured screening, & brief intervention (SBI) services, 15 -30 minutes (Recommended by AAP Coding for Pediatric Preventive Care)

CPT 99409 – Alcohol &/or substance abuse structured screening & brief intervention, greater than 30 minutes

HCPCS G0442 – Annual alcohol misuse screening, 15 minutes

HCPCS G0443 – Brief face -to-face behavioral counseling for alcohol misuse, 15 minutes

#### **ICD-10 Codes**

F10.10 – Nondependent alcohol abuse

F10.120 – Nondependent alcohol abuse

F10.129 – Nondependent alcohol abuse

Z71.41 – Alcohol abuse counseling

#### **Frequency**

Once annually

Annual counseling for those who test positive on screening

### **ANEMIA, SCREENING IN INFANTS, CHILDREN & ADOLESCENTS (Measure 49)**

The following screening for anemia is covered for all infant, children and adolescent members of "non-grandfathered" plans, without cost sharing (i.e., deductible, co-insurance or co-pay):

- Hemoglobin and hematocrit should be screened for at the 4-month well-child visit in infants who are preterm or who are low birth weight infants, and those infants not on iron-fortified formula.
- Hemoglobin and hematocrit should be screened routinely at the 12-month well-child visit.

- Hemoglobin & hematocrit should be screened selectively for children and adolescents who are positive for risk screening questions at 15 month – 21-year visits.

### **HRSA (Bright Futures) Recommendations (Effective on or after Sep 2010)**

Hemoglobin & hematocrit should be screened for at the 4 -month well -child visit in children who are preterm or who are low birth weight infants, and those not on iron -fortified formula

Hemoglobin & hematocrit should be screened for routinely at the 12 -month well -child visit

Hemoglobin & hematocrit should be screened selectively for children who are positive for risk screening questions at the 3 -21-year visits

### **CPT/HCPCS Codes**

CPT 85014 – Blood count, hematocrit

CPT 85018 – Blood count, hemoglobin

### **ICD-10 Code**

Z13.0 – Encounter for screening of the blood and blood forming organs

### **Frequency**

Once at 4 -month & once at 12 -month well child visit. Once at other well child visits for those who are at risk.

### **AUTISM, SCREENING (Measure 50)**

Autism specific screening is covered at the 18 month and 24-month well-child visits for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Provide the autism specific screening test at the 18 month well child visit

### **CPT/HCPCS Codes**

CPT 96110 – Developmental testing, limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

(Code 96110 is recommended by the AAP Coding for Pediatric Preventive Care, 2011)

HCPCS G0451 – Developmental testing, with interpretation & report, per standardized instrument form

### **ICD-10 Codes**

Z00.121 – Routine infant or child health check, for child over 28 days old

Z00.129 – Routine infant or child health check, for child over 28 days old

Z13.40 – Encounter for screening for certain developmental disorders in childhood

Z13.41 – Encounter for autism screening

Z13.42 – Encounter for screening for global developmental delays (milestone)

Z13.49 – Encounter for screening for other developmental delays

### **Frequency**

Once at the 18 month and 24 month well child visit

### **BACTERIURIA, SCREENING IN PREGNANT WOMEN (Measure 5)**

Screening for asymptomatic bacteriuria with urine culture for pregnant persons is covered for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay).

### **USPSTF Recommendation (Released Jul 2008; Effective on or after Sep 2010) (Updated and Re-Released September 2019)**

The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women. (Grade A)

### **CPT/HCPCS Codes**

CPT 87081 – Culture, presumptive, pathogenic organisms, screening only

CPT 87084 – Culture, presumptive, pathogenic organisms, screening; colony estimation from density chart

CPT 87086 – Culture, bacterial; quantitative colony count, urine

CPT 87088 – Culture, bacterial; with isolation and presumptive identification of each isolate, urine

### **ICD-10 Codes**

Z34.0 – Z34.93 – Prenatal Visits

O09 – O09.93 – Prenatal visits for patients with high -risk pregnancies

### **BICYCLE HELMET USE FOR CHILDREN & ADOLESCENTS, COUNSELING (Measure 63)**

Counseling for bicycle helmet use at well-child visits is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

### **HRSA (Bright Futures) Anticipatory Guidance (Effective Date on or after Jul 2012)**

Give parents who do not require their children to use a helmet, extensive information about the risks of bicycle –related head injuries, including the TIPP [AAP Injury Prevention Program] sheets and details of state or local legislation or regulations. Whenever available, provide discount coupons for approved helmets. Children who answer that they do not use a bicycle helmet should be given information appropriate to their age and cognitive level on the need for helmets.

(Performing Preventive Services: A Bright Futures Handbook)

### **CPT/HCPCS Codes**

CPT 99381 - Initial comprehensive preventive medicine early childhood infant (age less than 1 year)  
CPT 99382 – Initial comprehensive preventive medicine early childhood (age 1 through 4 years)  
CPT 99383 – Initial comprehensive preventive medicine late childhood (age 5 through 11 years)  
CPT 99384 – Initial comprehensive preventive medicine adolescent age (age 12 through 17 years)  
CPT 99385 – Initial comprehensive preventive medicine 18-39 years  
CPT 99391 – Periodic comprehensive preventive medicine early childhood (age less than 1 year)  
CPT 99392 – Periodic comprehensive preventive medicine early childhood (age 1 through 4 years)  
CPT 99393 – Periodic comprehensive preventive medicine late childhood (age 5 through 11 years)  
CPT 99394 – Periodic comprehensive preventive medicine adolescent (age 12 through 17 years)  
CPT 99395 – Periodic comprehensive preventive medicine 18 -39  
CPT 99401 – Preventive medicine counseling or risk factor reduction intervention(s), approximately 15 min

### **ICD-10 Codes**

Z00.00 – Routine general medical examination  
Z00.01 – Routine general medical  
Z00.121 – Routine infant and child health check for child over 28 days  
Z00.129 – Routine infant and child health check for child over 28 days  
Z00.8 - Encounter for other general examination  
Z71.89 – Other specified counseling

### **Frequency**

At well child visits

### **BRCA TESTING, GENETIC COUNSELING AND EVALUATION (Measure 7)**

Referral for genetic counseling is covered for women with family members with breast, ovarian, tubal, or peritoneal cancer who have been identified through screening with a family history that may be associated with an increased risk for the BRCA1 or BRCA2 genes. If indicated, after genetic counseling, BRCA testing is covered for these individuals. This coverage is for members of “non-grandfathered” plans on a once per lifetime basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Note: Screening is to be done with a specific screening tool designed to identify a family history that may be associated with the BRCA1 or BRCA2 mutation including but not limited to the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, and FHS-7.

### **USPSTF RECOMMENDATION (Released Sep 2005; Effective on or after Sep 2010)**

The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. (Grade B). HHS (2013 -02-20) has ruled that genetic testing & counseling must be covered without deductible, co -insurance, or co -pay. This will be effective 2013 -05-01.

### **USPSTF RECOMMENDATION (Released Sep 20 13; Effective on or after Sep 2014)**

The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. (Grade B)

### **CPT/ HCPCS Codes**

CPT 96040 – Genetic counseling service  
CPT 96041 – Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor  
CPT 99401 – Preventive medicine counseling, 15 minutes  
CPT 99402 – Preventive medicine counseling, 30 minutes  
CPT 99403 – Preventive medicine counseling, 45 minutes  
CPT 99404 – Preventive medicine counseling, 60 minutes  
CPT 81162 - BRCA1, BRCA2 gene analysis...  
CPT 81163 (eff 01/01/19) - BRCA1, BRCA2 gene analysis...  
CPT 81164 (eff 01/01/19) - BRCA1, BRCA2 gene analysis...  
CPT 81165 (eff 01/01/19) - BRCA1 gene analysis...  
CPT 81166 (eff 01/01/19) - BRCA1 gene analysis...  
CPT 81167 (eff 01/01/19) – BRCA 2 gene analysis...  
CPT 81212 – BRCA1 gene analysis  
CPT 81215 – BRCA 1 gene analysis...  
CPT 81216 – BRCA 2 gene analysis...  
CPT 81217 – BRCA2 gene analysis...  
HCPCS S0265 – Genetic counseling, under physician supervision, each 15 minutes

### **ICD-10 Codes**

Z31.5 – Genetic counseling  
Z80.3 – Family history of breast cancer  
Z80.41 – Family history of ovarian cancer  
Z80.49 – Family history of unspecified genital organ cancer  
Z85.3 - Personal history of breast cancer  
Z85.40 – Personal history of female genital organ, unspecified  
Z85.43 – Personal history of ovarian cancer  
Z85.44 – Personal history of other female genital organs

### **BREAST CANCER PREVENTION (Measure 10)**

Chemoprevention counseling by clinicians for women at high risk of breast cancer is covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

**USPSTF Recommendation (Released Jul 2002; Effective on or after Sep 2010; Re-Released Sep 2019)**

The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects. (Grade B)

**USPSTF Recommendation (Released Sep 2013; Effective on or after Sep 2014; Re-Released Sep 2019)**

Effective for members with contracts renewed on or after September 2014, (as of the plans date of renewal) tamoxifen and raloxifene or aromatase inhibitors (effective for members with contracts renewed on or after September 2020, as of the plans date of renewal), are covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) if all of the following criteria are met: **(This is a pharmacy benefit.)**

1. Asymptomatic women aged 35 years of age or older who have not had a previous diagnosis of breast cancer, ductal carcinoma in situ or lobular carcinoma in situ; AND
2. Have a high risk of breast cancer as determined by a formal breast cancer risk assessment tool (e.g., Breast Cancer Risk Assessment Tool available at [www.cancer.gov/bcrisktool](http://www.cancer.gov/bcrisktool)) administered by a health care professional; AND
3. Are at a low risk for adverse effects (e.g., no personal or family history of thromboembolic events)

**CPT/HCPCS Codes**

CPT 99385 – Initial comprehensive preventive medicine, 18 -39 years  
CPT 99386 – Initial comprehensive preventive medicine, 40 -64 years  
CPT 99387 – Initial comprehensive preventive medicine, 65 years & older  
CPT 99395 – Periodic comprehensive preventive medicine, 18 -39 years  
CPT 99396 – Periodic comprehensive preventive medicine, 40 -64 years  
CPT 99397 – Periodic comprehensive preventive medicine, 65 years & older  
CPT 99401 – Preventive medicine counseling, 15 minutes  
CPT 99402 – Preventive medicine counseling, 30 minutes  
CPT 99403 – Preventive medicine counseling, 45 minutes  
CPT 99404 – Preventive medicine counseling, 60 minutes  
HCPCS S0156 – Exemestane, 25 mg  
HCPCS S0170 – Anastrozole, oral, 1 mg  
HCPCS S0187 – Tamoxifen citrate, oral, 10 mg

**ICD-10 Codes**

D24.1 – D24.9 – Benign neoplasm of breast  
N60.81 – N60.89 – Other benign mammary dysplasia  
Z15.01 – Genetic susceptibility to breast cancer  
Z79.810 – Use of SERMs  
Z80.3 – Family history of breast cancer  
Z85.3 – Personal History of breast cancer

### Frequency

Once annually for women at high risk for breast cancer

### **BREAST CANCER, SCREENING (MAMMOGRAPHY) (Measure 6)**

Screening mammography, with or without clinical breast examination, is covered for women aged 40 years or older once per year for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay)

### **USPSTF Recommendation (Released 2009; PPACA mandates the Sep 2002 recommendation, Effective on or after Sep 2010) (Re-Released April 2024)**

The USPSTF recommends biennial screening mammography for women aged 40 to 74 years. The 2002 recommendation, which PPACA requires Health Plans to follow, recommends mammography screening with or without clinical breast exam, every 1 -2 years for women aged 40 and older.

\*\*The ACA defines the recommendations of the USPSTF regarding breast cancer services to “the most current other than those issued in or around November 2009”. Thus, coverage for mammography is guided by the 2002 USPSTF guideline. \*\*

**\*\*\*NOTE\*\*\*CPT 77063 coverage indications are per Arkansas Act 708 of 2017, codified as A.C.A. §23 -79-140.**

“Employer directed self -insured groups are not required to cover”

### **CPT/HCPCS Codes**

CPT 77063 - Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

CPT 77065 - Diagnostic mammography, including computer -aided detection (CAD) when performed; unilateral

CPT 77066 - Diagnostic mammography, including computer -aided detection (CAD) when performed; bilateral

CPT 77067 - Screening mammography, bilateral (2 -view study of each breast), including computer -aided detection (CAD) when performed

### **ICD-10 Codes**

Z12.31 – Screening mammogram

Z12.39 – Other screening for malignant neoplasm of breast

**Frequency**

Screening mammography annually for women 40 and over

**BREAST FEEDING, INTERVENTIONS TO SUPPORT (Measure 8)**

Counseling for breastfeeding is covered for members of “non-grandfathered” plans during pregnancy and after birth without cost-sharing (i.e., deductible, co-insurance, or co-pay)

**USPSTF Recommendation (Released Oct 2008; Effective on or after Sep 2010)**

The USPSTF recommends interventions during pregnancy and after birth to promote and support breast feeding.

**HRSA (WHI) Recommendation (Released Jul 2011; Effective Date on or after 1 Aug 2012) (Re-released Dec 2021)**

WPSI recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding.

**CPT/HCPCS Codes**

- CPT 99401 – Preventive medicine counseling; 15 minutes
- CPT 99402 – Preventive medicine counseling; 30 minutes
- CPT 99403 – Preventive medicine counseling; 45 minutes
- CPT 99404 – Preventive medicine counseling; 60 minutes
- HCPCS A4281 – Replacement tubing for breast pump
- HCPCS A4282 – Replacement adapter for breast pump
- HCPCS A4283 – Replacement cap for breast pump bottle
- HCPCS A4284 – Replacement breast shield and splash protector for use with breast pump
- HCPCS A4285 – Replacement polycarbonate bottle for use with breast pump
- HCPCS A4286 – Replacement locking ring for breast pump
- HCPCS A4287 – Disposable collection and storage bag for breast milk, any size, any type
- HCPCS A4288 – Valve for breast pump, replacement
- HCPCS E0602 – Breast pump, manual, any type
- HCPCS E0603 – Breast pump, electric, any type

**ICD-10 Code**

Z39.1 – Postpartum care and examination of lactating mothers

**Frequency**

Five consultations with physician or lactation specialist per pregnancy

Tubing for breast pump, replacement – One set per birth event

Adapter, for breast pump replacement – 1 per birth event (cannot be within 12 months of first purchase)

Cap for breast pump bottle, replacement – 2 every 12 months after birth event

Breast shield and splash protector for use with breast pump, replacement – 1 set of 2 shields per birth event

Polycarbonate bottle for use with breast pump, replacement - 2 replacement bottles every 12 months following birth event

Locking ring for breast pump, replacement – 2 every 12 months following birth event

Disposable collection and storage bag for breast milk, any size, any type - 100 bags every 30 days following birth event

Allow One (1) pump per pregnancy – E0602 or E0603

### **CARDIOMETABOLIC RISKS OF OBESITY IN CHILDREN AND ADOLESCENTS, COUNSELING (Measure 69)**

Screening for cardiometabolic risks of obesity is covered as part of the well-child visit for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay)

#### **HRSA (Bright Futures) Anticipatory Guidance (Effective on or after Jul 2012)**

Although Bright Futures does not include screening recommendations for this syndrome, the American Academy of Pediatrics has issued a recent policy statement regarding lipid screening & cardiovascular health in childhood, which includes blood pressure assessment. Anticipatory guidance to help children maintain normal blood lipids & blood pressure – 2 key components involved in metabolic syndrome – is a crucial part of preventive services for children & adolescents.

#### **CPT Codes**

CPT 99381 – Initial comprehensive preventive medicine, early childhood (age younger than 1 year)

CPT 99382 – Initial comprehensive preventive medicine, early childhood (age 1 through 4 years)

CPT 99383 – Initial comprehensive preventive medicine, late childhood (age 5 through 11 years)

CPT 99384 – Initial comprehensive preventive medicine, adolescent age (age 12 through 17 years)

CPT 99385 – Initial comprehensive preventive medicine, 18 -39 years

CPT 99391 – Periodic comprehensive preventive medicine, early childhood (age younger than 1 year)

CPT 99392 – Periodic comprehensive preventive medicine, early childhood (age 1 through 4 years)

CPT 99393 – Periodic comprehensive preventive medicine, late childhood (age 5 through 11 years)

CPT 99394 – Periodic comprehensive preventive medicine, adolescent (age 12 through 17 years)

CPT 99395 – Periodic comprehensive preventive medicine, 18 -39

### ICD-10 Codes

Z00.00 – Routine general medical examination

Z00.01 – Routine general medical examination

Z00.121 – Routine infant or child health care check, infant of child over 28 days old

Z00.129 – Routine infant or child health care check, infant of child over 28 days old

Z00.8 – Encounter for other general examination

### Frequency

Well-child visits are discussed in Measure 46 and are recommended at the following intervals: birth, first week after birth, at age 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 2 ½ years, 3 years, and then annually through the age of 21 years.

## **CERVICAL CANCER AND HUMAN PAPILLOMAVIRUS TESTING, SCREENING (Measure 9)**

### **1. For women aged 21 to 29 years:**

Screening for **cervical cancer** is covered for women of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) with cytology (Pap smear) alone every 3 years.

### **2. For women aged 30 to 65 years:**

Screening for **cervical cancer** is covered for women of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) with cytology (Pap smear) **alone every 3 years**

### **OR**

High-risk human papillomavirus DNA testing is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) for women **no more frequently than every 5 years**

### **OR**

High-risk human papillomavirus DNA testing in combination with cytology (cotesting) is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) for women **no more frequently than every 5 years**

**USPSTF Recommendation (Released Jan 2003; Effective on or after Sep 2010; Updated & Re-Released March 2012; Effective on or after March 2013)**

Effective Sep 2010 – Mar 2013, the USPSTF recommended screening for cervical cancer in women who have been sexually active & have a cervix. Effective Mar 2013, the USPSTF recommends screening for cervical cancer with Pap smear in women 21 to 65 years every 3 years; or for women who wish to lengthen the Interval, screening with Pap smear and Human Papilloma Virus (HPV) screening every 5 years. (Grade A)

### **HRSA (Bright Futures) Recommendation (Revised Mar 2014; Effective on or after Jan 2016)**

Bright Futures recommends adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the pediatric Office Setting"

### **CPT/HCPCS Codes**

CPT 88141 - 88143 – Cytopathology, cervical or vaginal  
CPT 88147 - 88148 – Cytopathology smears, cervical or vaginal  
CPT 88150, 88152 - 88153 – Cytopathology slides, cervical or vaginal  
CPT 88164 -88167 – Cytopathology slides, cervical or vaginal  
CPT 88174 -88175 – Cytopathology, cervical or vaginal  
HCPCS G0101 – Cervical or vaginal cancer screening  
HCPCS G0123 -G0124 – Screening cytopathology, cervical or vaginal  
HCPCS G0141 – Screening cytopathology smears, cervical or vaginal  
HCPCS G0143 - G0145 – Screening cytopathology smears, cervical or vaginal  
HCPCS G0147 - G0148 – Screening cytopathology smears, cervical or vaginal  
HCPCS P3000 - P3001 – Screening Papanicolaou smear  
HCPCS Q0091 – Screening Papanicolaou smear  
HCPCS S0610 – Annual gynecological exam, new patient  
HCPCS S0612 – Annual gynecological exam, established patient  
CPT 87624 – Human Papillomavirus (HPV), high risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)  
CPT 87625 – Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed  
CPT 87626 – Human Papillomavirus (HPV), separately reported high risk types (eg, 16, 18, 31, 45, 51, 52) and high-risk pooled results.  
HCPCS G0476 – Human Papillomavirus (HPV), high -risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test

### **ICD-10 Codes**

Z00.00 – General Medical Exam  
Z00.01 – Routine gynecological examination  
Z01.411 – Encounter for Pap cervical smear  
Z01.419 – Encounter for gynecological examination (general) (routine) without abnormal findings  
Z01.42 – Encounter for Pap cervical smear confirmation  
Z11.51 – Encounter for screening for human papillomavirus (HPV)  
Z12.4 – Special screening for malignant neoplasm of cervix  
Z12.72 – Encounter for screening for malignant neoplasm of vagina

### **Frequency**

Cervical Pap smears are covered once every three years (effective 1/1/2016)

HPV testing covered separately or in combination with cytology no more frequently than every five (5) years

### **CHLAMYDIA INFECTION, SCREENING IN WOMEN & ADOLESCENTS (Measures 11 and 12)**

Screening for chlamydial infection is covered up to once per year (unless pregnant more than once) for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay):

- for all sexually active women aged 24 and younger and for older women who are at increased risk;
- for adolescents aged 11- 21 years of age

#### **Recommendation (Released Jun 2007; Effective on or after Sep 2010) (Effective on or after Sept 2015) (Re -released Sept 2021)**

The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection. (Grade B)

#### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Screen sexually active adolescents for chlamydia using tests appropriate to the patient population & clinical setting. (Adolescent ages used are 11 -21, male or female)

#### **CPT/HCPCS Codes:**

CPT 87270 – Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis

CPT 87320 – Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis

CPT 87490 – Infectious agent detection by nucleic acid (DNA or RNA), Chlamydia trachomatis, direct probe

CPT 87491 – Infectious agent detection by nucleic acid (DNA or RNA), Chlamydia trachomatis, amplified probe

CPT 87800 – Infectious agent detection by nucleic acid (DNA or RNA), Chlamydia trachomatis, direct probe

CPT 87801 – Infectious agent detection by nucleic acid (DNA or RNA), Chlamydia trachomatis, amplified probe

CPT 87810 – Infectious agent antigen detection by immunoassay with direct optical observation, Chlamydia trachomatis

#### **ICD-10 Codes**

O09 – O09.40; O09.519; O09.529 – O09.93 – Prenatal visits for patients with high -risk pregnancies

Z00.00 – General Medical exam

Z00.01 – General Medical Exam

Z01.419 – Encounter for gynecological examination (general) (routine) without abnormal findings

Z11.3 – Encounter for screening for sexually transmitted infections

Z11.8 – Encounter for screening for other infectious diseases.

Z33.1 – Pregnant State, Incidental

Z34.0 – Z34.93 – Prenatal visits

Z72.51 – Z72.53 – High risk sexual behavior

### **Frequency**

Allowed once per year

### **COLORECTAL CANCER, SCREENING (Measure 13) (Also refer to Other preventive services for ACT 779)**

In accordance with Act 779 [Colorectal Cancer Screening] of the Arkansas legislature for all contracts subject to this law: a) coverage of colorectal cancer screening is provided at no cost -share for covered persons aged 45 years or older and b) extended coverage of colorectal cancer screening is provided at no cost -share when covered person meets criteria for high risk.

For contracts subject to Arkansas Act 779, a colonoscopy that is performed as a follow-up to a colorectal cancer screening test, other than a colonoscopy, will be covered at no cost -share when the initial screening test resulted in a positive and the initial screening test is assigned a grade of “A” or a grade of “B” by the United States Preventive Services Task Force.

Colonoscopy remains the preferred testing method for individuals at average and high risk of colorectal cancer including those with a family history of colorectal cancer, individuals with a previous screenings that was positive for adenomatous or precancerous polyps, or for those otherwise acknowledged as high risk for colorectal cancer [including, but not limited to, a personal history of colorectal cancer, a personal history of inflammatory bowel disease such as Crohn’s disease or ulcerative colitis, or a personal diagnosis of a genetic condition causing an increased risk of colorectal cancer].

### **Effective July 1, 2026**

Screening for colorectal cancer using the following techniques is covered for all adults aged 45 to 75 years without cost sharing (i.e., deductible, co-insurance, or co-pay).

- Fecal immunochemical test [FIT] (annually) or guaiac fecal occult blood test (gFOBT) (annually)
- CT colonography (every 5 years)
- Sigmoidoscopy (every 5 years OR every 10 years when combined with annual FIT)
- Colonoscopy (every 10 years)
- Stool DNA FIT test (i.e., Cologuard or Cologuard Plus) (every 3 years) (This test is intended for testing individuals at average risk for colorectal cancer, it is not covered for individuals at high risk of colorectal cancer.)

Stool-based screening (i.e., FIT, gFOBT) and Stool DNA FIT testing (i.e., Cologuard or Cologuard Plus) performed as a screening test for colorectal cancer will not be allowed in any situation other than those described above. Stool DNA FIT testing (i.e., Cologuard or Cologuard Plus) is not covered for diagnostic testing.

If non-stool-based screening (e.g., CT colonography, Sigmoidoscopy, Colonoscopy) for colorectal cancer has been performed, stool-based screening (i.e., FIT, gFOBT) and/or stool DNA testing (i.e., Cologuard or Cologuard Plus) will not be allowed in the same year in any situation other than those described above. If a stool-based screening or stool DNA screening has been done, an additional stool-based screening or stool DNA test will not be allowed in the same year.

A follow-up colonoscopy to evaluate abnormal results found on a stool-based colorectal screening test or following flexible sigmoidoscopy or CT colonography is covered. The colonoscopy will be covered without cost share (i.e., deductible, co-insurance, or co-pay) for adults aged 45 - 75 years who have not received a colonoscopy in the last 10 years (e.g., colonoscopy is recommended by the USPSTF for colorectal cancer screening every 10 years for asymptomatic adults aged 45-75).

**Note:** *A follow-up colonoscopy to evaluate abnormal results found on a stool-based colorectal screening test or following flexible sigmoidoscopy or CT colonography rendered more frequently than every 10 years is covered but will be subject to deductible, co-insurance, and co-pay.*

#### **Effective January 1, 2024 – June 30, 2026**

Screening for colorectal cancer using the following techniques is covered for all adults aged 45 to 75 years without cost sharing (i.e., deductible, co-insurance, or co-pay).

- Fecal immunochemical test [FIT] (annually) or guaiac fecal occult blood test (gFOBT) (annually)
- CT colonography (every 5 years)
- Sigmoidoscopy (every 5 years OR every 10 years when combined with annual FIT)
- Colonoscopy (every 10 years)
- Stool DNA FIT test (i.e., Cologuard) (every 3 years) (This test is intended for testing individuals at average risk for colorectal cancer, it is not covered for individuals at high risk of colorectal cancer.)

Stool-based screening (i.e., FIT, gFOBT) and Stool DNA FIT testing (i.e., Cologuard) performed as a screening test for colorectal cancer will not be allowed in any situation other than those described above. Stool DNA FIT testing (i.e., Cologuard) is not covered for diagnostic testing.

If non-stool-based screening (e.g., CT colonography, Sigmoidoscopy, Colonoscopy) for colorectal cancer has been performed, stool-based screening (i.e., FIT, gFOBT) and/or stool DNA testing (i.e., Cologuard) will not be allowed in the same year in any situation other than those described above. If a stool-based screening or stool DNA screening has been done, an additional stool-based screening or stool DNA test will not be allowed in the same year.

A follow-up colonoscopy to evaluate abnormal results found on a stool-based colorectal screening test or following flexible sigmoidoscopy or CT colonography is covered. The

colonoscopy will be covered without cost share (i.e., deductible, co-insurance, or co-pay) for adults aged 45 - 75 years who have not received a colonoscopy in the last 10 years (e.g., colonoscopy is recommended by the USPSTF for colorectal cancer screening every 10 years for asymptomatic adults aged 45-75).

**Note:** A follow-up colonoscopy to evaluate abnormal results found on a stool-based colorectal screening test or following flexible sigmoidoscopy or CT colonography rendered more frequently than every 10 years is covered but will be subject to deductible, co-insurance, and co-pay.

**USPSTF Recommendation (Released Oct 2008; Effective on or before Sep 2010) (Re-Released May 2021)**

The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. (Grade A)

The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. (Grade B)

A follow-up colonoscopy to evaluate abnormal results found on a stool -based colorectal screening test or following flexible sigmoidoscopy or CT colonography is covered. The colonoscopy will be covered without cost share (i.e., deductible, co -insurance, or co -pay) for adults aged 45 - 75 years who have not received a colonoscopy in the last 10 years (e.g., colonoscopy is recommended by the USPSTF for colorectal cancer screening every 10 years for asymptomatic adults aged 45 -75). To be effective as of January 1, 2024.

**CPT/HCPCS Codes:**

Appending modifier '33' to any of the codes in the measure identifies it as a screening procedure.

It is possible that a screening study is converted to a diagnostic study or an intervention. When a screening study is converted to a diagnostic or interventional procedure no cost sharing will be applied.

When these services are billed for a screening study converted to a diagnostic study or intervention, they may be billed with **Modifier -33** or **Modifier -PT** – colorectal cancer screening test; converted to diagnostic test or other procedure. Appending modifier -PT provides identification of the SURGICAL or ANESTHESIA procedure as a preventive service.

Additionally, the related code CPT 88305 may be billed with this service and should be billed using **Modifier -33**. **Modifier -PT** is not valid with this code.

CPT 00812 – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

CPT 0464U - Oncology (colorectal) screening, quantitative real time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result (effective 7/1/2026)

CPT 45330 - Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

CPT 45331 – Sigmoidoscopy, flexible; with biopsy, single or multiple  
CPT 45332 – Sigmoidoscopy, flexible; with removal of foreign body(s)  
CPT 45333 – Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s); by hot biopsy forceps or bipolar cautery  
CPT 45334 – Sigmoidoscopy, flexible; with control of bleeding, any method  
CPT 45335 – Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance  
CPT 45338 – Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s); by snare  
CPT 45346 - Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre and post dilation and guide wire passage, when performed)  
CPT 45378 – Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression  
CPT 45379 – Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body(s)  
CPT 45380 – Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple  
CPT 45381 – Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection  
CPT 45382 – Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding, any method  
CPT 45384 – Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery  
CPT 45385 – Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare  
CPT 45388 – Colonoscopy, flexible; with ablation or tumor(s), polyp(s), or other lesions (includes pre - and post - dilation and guide wire passage, when performed)  
CPT 74263 – Computed tomographic (CT) colonography, screening, including image postprocessing  
CPT 81528 – MT-DNA + FIT (e.g., Cologuard)  
CPT 82270 – Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple cards for consecutive collection)  
CPT 82274 – Blood, occult, by fecal hemoglobin determined by immunoassay, qualitative, feces, 1 -3 Simultaneous determinations  
CPT 88305 – Level IV – Surgical pathology, gross & microscopic examination  
CPT 99152 - Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older  
CPT 99153 – Moderate Sedation provided by same physician or health care professional requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; ea. Additional 15 min intraservice time. (list separately in addition to code for primary service)  
HCPCS G0104 – Colorectal cancer screening; flexible sigmoidoscopy  
HCPCS G0105 – Colorectal cancer screening; colonoscopy on individual at high risk  
HCPCS G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk  
HCPCS G0328 – Colorectal cancer screening; fecal -occult blood test, immunoassay, 1 -3 simultaneous

HCPCS G0500 – Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)

### **ICD-10 Codes**

Z12.11 – Screening for malignant neoplasm of the colon  
Z12.12 – Special screening for malignant neoplasms, rectum

### **Frequency**

There are 5 covered screening services:

- 1) Fecal immunochemical testing, annually.
- 2) MT-DNA +FIT, once every 3 years (patients with average risk [ICD10: Z12.10 -Z12.12 only] when no other recommended USPSTF colorectal cancer screening services have been provided in preceding 12 months).
- 3) Flexible sigmoidoscopy every 5 years OR every 10 years in combination with annual FIT.
- 4) CT colonography every 5 years.
- 5) Flexible colonoscopy every 10 years

### **NEWBORN SCREENINGS FOR INHERITED DISORDERS (Measure 51)**

Newborn screening tests are covered for newborn members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

*Note: Newborn screening tests as required by the State of Arkansas and Bright Futures.*

Under Arkansas Act 490 UNIVERSAL NEWBORN SCREENING ACT, the Arkansas Department of Health is directed to provide for newborn screening in keeping with the requirements of the Recommended Uniform Screening Panel (RUSP) for all births in the state of Arkansas.

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2012)**

Conduct screening as required by state (Arkansas statute requires newborn screening for designated inborn errors of metabolism and hemoglobinopathies; usually done during the birthing hospitalization.

### **CPT/HCPCS Codes**

HCPCS S3620 – Newborn metabolic screening panel, includes test kit, postage, and the laboratory tests specified by the state for inclusion of the panel

### **ICD-10 Codes**

Z00.110 – Health supervision for newborn under 8 days old  
Z00.111 – Health examination for newborn 8 to 28 days old

## Frequency

Allowed once in a lifetime during the first month of life

## **CONTRACEPTIVE USE & COUNSELING (Measure 60)**

Food and Drug Administration-approved contraceptive methods (not including abortifacient drugs), sterilization procedures and patient education and counseling, are covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) for all women of child-bearing potential (this includes adolescents of child-bearing potential).

There is a \$0 co -payment for all generic prescription contraceptives. If there is no generic in the class/subclass, then brand contraceptive is at \$0 copayment.

Emergency contraceptives for members who are less than 18 years old for Plan B and those who are less than 17 years old for Plan B One-Step are covered if a prescription is presented for coverage.

## **HRSA (WHI) Recommendation (Released Jul 2011; Effective on or after 1 Aug 2012) (Re-Released January 2022)**

The Women’s Preventive Services Initiative (WPSI) recommends that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve health outcomes.

Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (e.g., management, evaluation, and changes, including the removal, continuation, and discontinuation of contraceptives).

## **CPT/HCPCS Codes**

CPT 00851 – Anesthesia for tubal ligation/transection

CPT 11976 – Removal, implantable contraceptive capsules

CPT 11980 – Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin

CPT 11981 – Insertion, non -biodegradable drug delivery implant (e.g., Implanon)

CPT 11982 – Removal, non -biodegradable drug delivery implant

CPT 11983 – Removal with reinsertion, non -biodegradable drug delivery implant

CPT 57170 – Diaphragm or cervical cap fitting with instructions

CPT 58300 – Insertion of intrauterine device (IUD)

CPT 58301 – Removal of intrauterine device (IUD)

CPT 58340 – Catheterization & introduction of saline or contrast material for saline infusion hysterosonography or hysterosalpingography

CPT 58600 – Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

CPT 58605 – Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, Unilateral or bilateral, during same hospitalization  
CPT +58611 – Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or Intra-abdominal surgery  
CPT 58615 – Occlusion of fallopian tube(s), by device (e.g., band, clip, Fal ope ring) vaginal or suprapubic approach  
CPT 58670 - Laparoscopy, surgical; with fulguration of oviducts (with or without transection)  
CPT 58671 – Laparoscopy, surgical, with occlusion of oviducts by device (e.g., band, clip, or Falope ring)  
CPT 74740 – Hysterosalpingography, radiological S&I  
CPT 96372 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug), subcutaneous or Intramuscular (e.g., Lunelle)  
CPT 99202 – New Patient Office or other outpatient visit, low to moderate severity  
CPT 99203 – New patient office or other outpatient visit, Moderate severity  
CPT 99204 – New patient office or other outpatient visit, Moderate to high severity  
CPT 99205 – New patient office or other outpatient visit, Moderate to high severity  
CPT 99212 – Established patient office or other outpatient visit, minor problem  
CPT 99213 – Established patient office or other outpatient visit, low to moderate severity  
CPT 99214 – Established patient office or other outpatient visit, moderate to high severity  
CPT 99215 – Established patient office or other outpatient visit, moderate to high severity  
CPT 99384 – Initial comprehensive preventive medicine, 12 -17 years  
CPT 99385 – Initial comprehensive preventive medicine, 18 -39 years  
CPT 99386 – Initial comprehensive preventive medicine, 40 -64 years  
CPT 99394 – Periodic comprehensive preventive medicine reevaluation & management, 12 -17  
CPT 99395 – Periodic comprehensive preventive medicine reevaluation & management, 18 -39  
CPT 99396 – Periodic comprehensive preventive medicine reevaluation & management, 40 -64  
HCPCS S4981 – Insertion of levonorgestrel -releasing intrauterine system (e.g., Mirena)  
HCPCS S4989 – Contraceptive intrauterine device (e.g., Progestasert IUD)  
HCPCS S4993 – Contraceptive pill for birth control (Only billed by Family Planning Clinics)  
HCPCS A4261 – Cervical cap for contraceptive use  
HCPCS A4266 – Diaphragm for contraceptive use  
HCPCS A4267 – Contraceptive supply, condom, male, each  
HCPCS A4268 – Contraceptive supply, condom, female, each  
HCPCS A4269 – Contraceptive supply, spermicide (e.g., foam, gel), each  
HCPCS J1050 – Medroxyprogesterone acetate, 1 mg  
HCPCS J7294 – Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each  
HCPCS J7295 – Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each  
HCPCS J7296 – Levonorgestrel -releasing intrauterine contraceptive system, (kyleena), 19.5 mg  
HCPCS J7297 – Levonorgestrel -releasing intrauterine contraceptive system, 52 mg, 3 year duration  
HCPCS J7298 – Levonorgestrel -releasing intrauterine contraceptive system, 52 mg, 5 year duration  
HCPCS J7300 – Intrauterine copper contraceptive  
HCPCS J7301 – Levonorgestrel -releasing intrauterine contraceptive system (i.e., Skyla)  
HCPCS J7304 – Contraceptive supply, hormone containing patch  
HCPCS J7306 – Levonorgestrel (contraceptive) imp lant system, including implants and supplies  
HCPCS J7307 – Etonogestrel implant system, including implant and supplies

## ICD-10 CODES

Z30.011 – Prescription of oral contraceptives  
Z30.012 – Encounter for prescription of emergency contraception  
Z30.013 – Encounter for injectable contraceptive  
Z30.014 – Encounter for insertion of intrauterine contraceptive device  
Z30.015 - Encounter for initial prescription of vaginal ring hormonal contraceptive  
Z30.016 - Encounter for initial prescription of transdermal patch hormonal contraceptive device  
Z30.017 - Encounter for initial prescription of implantable subdermal contraceptive  
Z30.018 – Encounter for initial prescription for other contraceptive  
Z30.019 – Encounter for initial prescription for contraceptive, unspecified  
Z30.02 – Counseling and instruction in natural family planning to avoid pregnancy  
Z30.09 – Encounter for contraceptive management, general counseling and advice, other  
Z30.2 – Sterilization  
Z30.40 – Contraceptive surveillance, unspecified  
Z30.41 – Contraceptive pill surveillance  
Z30.42 – Injectable contraceptive surveillance  
Z30.430 – Insertion of Intrauterine contraceptive device  
Z30.431 – Routine checking of Intrauterine contraceptive device  
Z43.432 - Encounter for removal of intrauterine contraceptive device  
Z30.433 – Encounter for removal & reinsertion of intrauterine contraceptive device  
Z30.44 - Encounter for surveillance of vaginal ring hormonal contraceptive device  
Z30.45 - Encounter for surveillance of transdermal patch hormonal contraceptive device  
Z30.46 – Encounter for surveillance of implantable subdermal contraceptive  
Z30.49 – Contraceptive surveillance, other  
Z30.8 – Other specified contraceptive management  
Z30.9 – Unspecified contraceptive management

## DENTAL CARIES IN PRESCHOOL CHILDREN (Measure 14)

Counseling for treatment with oral fluoride supplementation is covered for children whose primary water source is deficient in fluoride for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) as part of a normal wellness office visit at 6mos, 9 mos., 12 mos., 18 mos., 24 mos., 30 mos., and yearly from 3 years to 16 years.

The application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption is covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

## USPSTF Recommendation (Released Apr 2004; Effective on or after Sep 2010)

The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. (Grade B)

USPSTF Recommendation (Released May 2014; Effective on or after Jun 2015)

The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. (Grade B)

**HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010) (Revised August 2017)**

Oral fluoride supplementation if the primary water source is deficient in fluoride for members of “non -grandfathered” plans, without cost -sharing (i.e., deductible, co -insurance, or co -pay) as part of a normal wellness office visit at 6mos, 9 mos., 12 mos., 18 mos., 24 mos., 30 mos., and yearly from 3 years to 16 years.

**CPT HCPCS Codes:**

- CPT 99188 – Application of topical fluoride varnish by a physician
- CPT 99381 – Initial comprehensive preventive medicine evaluation & management, infant up to 1 year
- CPT 99382 – Initial comprehensive preventive medicine evaluation & management, 1 through 4 years
- CPT 99383 – Initial comprehensive preventive medicine evaluation & management, 5 through 11 years
- CPT 99391 – Periodic comprehensive preventive medicine reevaluation and management, infant up to 1 year
- CPT 99392 – Periodic comprehensive preventive medicine reevaluation and management, 1 through 4 years
- CPT 99393 – Periodic comprehensive preventive medicine reevaluation and management, 5 through 11 years

**ICD-10 Codes**

- Z00.121 – Routine infant or child health check
- Z00.129 – Routine infant or child health check
- Z41.8 – Encounter for other procedures for purposes other than remedying health state

**Frequency**

Fluoride may be prescribed until the child reaches school age

Counseling for treatment with oral fluoride supplementation as part of a normal wellness office visit at 6mos, 9 mos, 12 mos, 18 mos, 24 months, 30 mos, and yearly from 3 years to 16 years

**DEPRESSION AND ANXIETY SCREENING, ADULTS (Measure 15)**

*For contracts subject to Arkansas Act 316, SCREENING FOR DEPRESSION OF BIRTH MOTHERS, [individual, blanket, or any group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self -insured governmental or church plan in this state (all fully -insured and state government such as ASE/PSE, ASP)] coverage shall be*

*provided for depression screening for birth mothers at the time of birth or within the first six weeks of birth. For all contracts not subject to Ark law [e.g. federally chartered contracts such as ERISA groups, Federal Employee Health Benefit Program, and Medicare Advantage], these benefits will be provided as directed by PPACA.*

### **Effective January 2025**

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Screening for anxiety in adults, including those who are pregnant or postpartum, is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay, or co-insurance).

### **Effective August 1, 2024- December 2024**

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Screening for anxiety in adult women, including those who are pregnant or postpartum, is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay, or co-insurance).

### **USPSTF Recommendation for Depression (Released Dec 2009; Effective on or after Sep 2010) (Updated June 2023)**

The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults. (Grade B)

### **USPSTF Recommendation for Anxiety (Released June 2023; Effective on or after Jan 2025)**

The USPSTF recommends screening for anxiety in adults, including those who are pregnant or postpartum, and is covered for members of “non -grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co -pay, or co-insurance.)

### **HRSA Recommendation (Effective 01/01/2023)**

**WPSI recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.**

### **CPT/HCPCS Codes:**

CPT 96127 - Brief emotional/behavioral assessment (eg, depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

CPT 96160 - Administration of patient focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

CPT 96161 - Administration of caregiver focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

CPT 99385 – Initial comprehensive preventive medicine, 18 -39 years

CPT 99386 – Initial comprehensive preventive medicine, 40 -64 years

CPT 99387 – Initial comprehensive preventive medicine, 65 years & older

CPT 99395 – Periodic comprehensive preventive medicine, 18 -39 years

CPT 99396 – Periodic comprehensive preventive medicine, 40 -64 years

CPT 99397 – Periodic comprehensive preventive medicine, 65 years & older

CPT 99401 – Preventive medicine counseling; approximately 15 minutes

CPT 99402 – Preventive medicine counseling; approximately 30 minutes

CPT 99403 – Preventive medicine counseling; approximately 45 minutes

CPT 99404 – Preventive medicine counseling; approximately 60 minutes

HCPCS G0444 – Depression screening, 15 minutes

### ICD-10 Codes

Z13.30 – Encounter for screening examination for mental health and behavioral disorders, unspecified

Z13.31 – Encounter for screening for depression

Z13.32 – Encounter for screening for maternal depression

Z13.39 – Encounter for screening examination for other mental health and behavioral disorders

### Frequency

Once per year

### DEPRESSION AND ANXIETY, SCREENING IN ADOLESCENTS (Measure 16)

*For contracts subject to Arkansas Act 316, SCREENING FOR DEPRESSION OF BIRTH MOTHERS, [individual, blanket, or any group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state (all fully-insured and state government such as ASE/PSE, ASP)] coverage shall be provided for depression screening for birth mothers at the time of birth or within the first six weeks of birth. For all contracts not subject to Ark law [e.g. federally chartered contracts such as ERISA groups, Federal Employee Health Benefit Program, and Medicare Advantage], these benefits will be provided as directed by PPACA.*

### Effective January 1, 2024

Screening for depression in adolescents 11-21 years of age is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay, or co-insurance).

Screening for anxiety in children and adolescents aged 8 to 18 years is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay or co-insurance).

**Effective August 1, 2023 – December 31, 2023**

Screening for depression in adolescents 11-21 years of age is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay, or co-insurance).

Screening for anxiety in adolescent females 13 years of age and older is covered for members of “non-grandfathered” plans on an annual basis without cost sharing (i.e., deductible, co-pay, or co-insurance).

**USPSTF Recommendation (Released Mar 2009; Effective on or after Sep 2010) (Re - Released Feb 2016)**

The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.

Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.(Grade B)

**USPSTF Recommendation (Released October 2022; Effective on or after January 2024)**

The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years. (Grade B)

**HRSA (Bright Futures) Recommendation (Revision Published Mar 2014; Effective on or after January 2016)**

Bright Futures recommends screening for depression at ages 11 through 21, along with suggested screening tools.

**HRSA Recommendation (Effective 01/01/2023)**

WPSI recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.

**CPT/ HCPCS Codes:**

CPT 96127 – Brief emotional/behavioral assessment (eg, depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

CPT 96160 – Administration of patient focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

CPT 96161 – Administration of caregiver focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

CPT 99383 – Initial comprehensive preventive medicine evaluation & management, adolescent (11)

CPT 99384 – Initial comprehensive preventive medicine evaluation & management, adolescent (12 -17)

CPT 99385 – Initial comprehensive preventive medicine evaluation & management, 18 -39 years

CPT 99393 – Periodic comprehensive preventive medicine evaluation & management, adolescent (11)

CPT 99394 – Periodic comprehensive preventive medicine reevaluation and management, adolescent (12 -17)

CPT 99395 – Periodic comprehensive preventive medicine reevaluation and management, 18 – 39 years

CPT 99401 – Preventive medicine counseling; approximately 15 minutes

CPT 99402 – Preventive medicine counseling; approximately 30 minutes

CPT 99403 – Preventive medicine counseling; approximately 45 minutes

CPT 99404 – Preventive medicine counseling; approximately 60 minutes

HCPCS G0444 – Depression screening, 15 minutes

### **ICD-10 Codes**

Z13.30 – Encounter for screening examination for mental health and behavioral disorders, unspecified

Z13.31 – Encounter for screening for depression

Z13.32 – Encounter for screening for maternal depression

Z13.39 – Encounter for screening examination for other mental health and behavioral disorders

### **Frequency**

Once per year

### **DEVELOPMENTAL SCREENING (Measure 52)**

Structured developmental screening is covered at the 9-month, 18 month and 2 ½ year well-child visits for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

### **HRSA (Bright Futures) Recommendation (Effective Sep 2010)**

Begin structured developmental screening at the 9 month well child visit, repeat at the 18 month well child visit, with repeat evaluation at 2½ years

### **CPT/HCPCS Codes**

CPT 96110 – Developmental testing, limited (e.g., Developmental test II, Early Language Milestone Screen), with interpretation and report (Code recommended by AAP (Coding for Pediatric Preventive (Code 96110 recommended by AAP [Coding for Preventive Care, 2011])

CPT 96127 - Brief emotional/behavioral assessment (eg, depression inventory, attention - deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

HCPCS G0451 – Developmental testing, with interpretation and report, per standardized instrument form)

### ICD-10 Codes

Z13.40 – Encounter for screening for unspecified developmental delays  
Z13.41 – Encounter for autism screening  
Z13.42 – Encounter for screening for global developmental delays (milestones)  
Z13.49 – Encounter for screening for other developmental delays

### Frequency

At the well child visit at age 9 months, 18 months and 2½ years

### DIABETES MELLITUS, TYPE 2, SCREENING IN ADULTS (Measure 17)

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions. Screening will be allowed once a year and counseling sessions will be limited to 12 sessions a year.

### USPSTF Recommendation (Released Jun 2008; Effective on or after Sep 2010) (update Oct 2015, eff Jan 2017) (Re -released August 2021)

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions. (Grade B)

### CPT/HCPCS Codes

CPT 82947 – Glucose; quantitative, blood (Except reagent strip)  
CPT 82950 – (Glucose, post glucose dose (includes glucose  
CPT 82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)  
CPT 82952 – Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)  
CPT 83036 – Hemoglobin, glycosylated (A1C)  
CPT 99401 – Preventive medicine counseling; approximately 15 minutes  
CPT 99402 – Preventive medicine counseling; approximately 30 minutes  
CPT 99403 – Preventive medicine counseling; approximately 45 minutes  
CPT 99404 – Preventive medicine counseling; approximately 60 minutes  
HCPCS G0447 – Face -to-face behavioral counseling for obesity, 15 minutes  
HCPCS G0473 – Face -to-face behavioral counseling for obesity, group (2 -10), 30 minutes

### ICD-10 Codes

Z00.00 – General Medical Exam  
Z00.01 - General Medical Exam  
Z13.1 – screening for diabetes mellitus

### Frequency

Allowed on an annual basis

Counseling limited to 12 sessions per calendar year or contract year

## **GESTATIONAL AND POSTPARTUM DIABETES SCREENING (Measure 64)**

### **Effective January 1, 2024**

Screening for gestational diabetes during pregnancy is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance, or co-pay):

- Before 24 weeks of gestation (ideally at the first prenatal visit) for pregnant women with risk factors for type 2 diabetes or gestational diabetes
- After 24 weeks of gestation (preferably between 24 – 28 weeks of gestation) for asymptomatic pregnant women

Screening for diabetes mellitus after pregnancy is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance, or co-pay) for women:

- With a history of gestational diabetes mellitus **and**
- Who are not currently pregnant **and**
- Who have not previously been diagnosed with type 2 diabetes mellitus.

\*Note: Initial testing should ideally occur within the first year postpartum and can occur as early as 4-6 weeks postpartum.

Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test should be screened every 3 years for a minimum of 10 years after pregnancy.

For those with a positive postpartum screening test result, testing should be repeated to confirm the diagnosis of diabetes regardless of the initial testing method (e.g., oral glucose tolerance test, fasting plasma glucose, or Hemoglobin A1c).

Repeat screening for diabetes mellitus is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance, or co-pay) for women who were screened with hemoglobin A1c in the first 6 months postpartum regardless of whether screening result was positive or negative.

### **USPSTF Recommendation (Release January 2014; Re -Released August 2021)**

The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after. (Grade B)

### **HRSA Recommendation (Released Nov 2022; Effective on or after 1 Jan 2024)**

WPSI recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. WPSI recommends screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation —ideally at the first prenatal visit.

WPSI recommends screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4 –6 weeks postpartum. Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (e.g., fasting plasma glucose, hemoglobin A1c, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1c in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1c test is less accurate during the first 6 months postpartum.

#### **CPT/HCPCS Codes**

CPT 82947 – Glucose; quantitative, blood (Except reagent strip)  
CPT 82950 – (Glucose, post glucose dose (includes glucose)  
CPT 82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)  
CPT 82952 – Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)  
CPT 83036 – Hemoglobin, glycosylated (A1C)

#### **ICD-10 Codes**

O09-O09.4, O09.519, O09.529 -O09.93) – Prenatal visits for high-risk pregnancies  
Z13.1 – Screening for diabetes mellitus  
Z33.1 – Pregnant state, incidental  
Z34.00 – Z34.93 – Prenatal visits  
Z39.0 – Encounter for care and examination of mother immediately after delivery  
Z39.1 – Encounter for care and examination of lactating mother  
Z39.2 – Encounter for routine postpartum follow -up  
Z86.32 – Personal history of gestational diabetes

#### **FREQUENCY**

Allowed at first prenatal visit and at least 24 weeks gestation; then annually thereafter

#### **FOLIC ACID, PREVENTION OF NEURAL TUBE DEFECTS (Measure 19)**

Counseling for folic acid supplementation for all women planning or capable of pregnancy is covered for members of “non-grandfathered” plans on an annual basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay). Over the counter folic acid supplementation is not covered.

#### **USPSTF Recommendation (Released May 2009; Effective on or after Sep 2010)**

The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. (Grade A)

Not routinely covered for all women capable of being pregnant.

#### **CPT/HCPCS Codes**

None.

Information on folic acid is typically provided during an office visit. No specific codes: part of well-woman visit

#### **ICD-10 Codes**

Z00.00 – General Medical Exam

Z00.01 – General Medical Exam

Z32.2 – Z32.3 – Encounter for childbirth/childcare instruction

Z71.89 – Other specified counseling

#### **Frequency**

Allowed if prescribed by a physician

#### **GONORRHEA, PROPHYLAXIS, NEWBORN OPHTHALMIC (Measure 21)**

Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum within the first 28 days of life is covered without cost sharing (i.e., deductible, co-pay or co-insurance).

#### **USPSTF Recommendation (Released May 2005; Effective on or after Sep 2010)**

The USPSTF strongly recommends prophylactic ocular topical medications for all newborns against ophthalmia neonatorum. (Grade A)

#### **CPT/HCPCS Code**

CPT 99461 – Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center

CPT 99381 – Initial comprehensive preventive medicine evaluation and management, infant

#### **ICD-10 Codes**

Z00.110 – Health supervision for newborn under 8 days old

Z00.111 – Health supervision for newborn 8 to 28 days old

#### **FREQUENCY**

Allowed once per lifetime in the first month of life.

### **GONORRHEA, SCREENING (Measure 20)**

Screening for gonorrhea infection is covered without cost sharing (i.e., deductible, co-insurance or co-pay) for:

- All sexually active women aged 24 and younger and older women who are at increased risk for infection.
- Adolescents aged 11-21 years of age

### **USPSTF Recommendation (Released May 2005; Effective on or after Sep 2010) (Re - Released Sept 2014) (Re-released Sep 2021)**

The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection. (Grade B)

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Screen sexually active adolescents between 11 -21 years of age using tests appropriate to the patient population and clinical setting.

### **CPT/HCPCS Codes**

CPT 87590 – Infectious agent detection by nucleic acid (DNA or RNA), *Neisseria gonorrhoeae*, direct probe technique

CPT 87591 – Infectious agent detection by nucleic acid (DNA or RNA), *Neisseria gonorrhoeae*, amplified probe technique

CPT 87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms, direct probe(s) technique

CPT 87801 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms, amplified probe(s) technique

CPT 87850 – Infectious agent antigen detection by immunoassay with direct optical observation; *Neisseria gonorrhoeae*

### **ICD-10 Codes**

O09 – O09.40, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies

Z00.00 – General medical exam

Z00.01 – General medical exam

Z01.419 – Encounter for gynecological examination (general) (routine) without abnormal findings

Z11.3 – Special screening exam for venereal disease

Z33.1 – Pregnant State

Z34.00 -Z34.93 - Prenatal visits

Z72.51 -Z72.53 – High risk sexual behavior

### **Frequency**

Allowed once per year

### **HEARING LOSS, SCREENING IN NEWBORNS & Up to Age 21 (Measure 22)**

Screening for hearing loss in children is covered for members of “non-grandfathered plans” without cost sharing, (i.e., deductible, co-pay, or co-insurance) as follows:

- All newborn infants (if not done at birth [e.g., newborn delivered at home or discharged from Neonatal Intensive Care Unit], screening should be completed within the first month of life);
- At the 4th through the 36th month visits, the 7-year visit, and 9-year visit, if there are positive responses to risk screening question, diagnostic audiologic assessment should be performed;
- At the 4th, 5th, 6th, 8th, and 10th year, audiometry is recommended;
- Audiometry screening with 6,000 and 8,000 Hz high frequencies is recommended once between 11 through 14 years of age, once between 15 through 17 years of age, and once between 18 through 21 years of age.

#### **USPSTF Recommendation (Released Jul 2008; Effective on or after Sep 2010)**

USPSTF recommends screening for hearing loss in all newborn infants. (Grade B)

#### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

If not done at birth (e.g., newborn delivered at home or discharged from Neonatal Intensive Care Unit), screening should be completed within the first month of life.

At the 4th through the 36 month, the 7 - and 9 -year visit, if there are positive responses to risk screening questions, the infant should be referred for have diagnostic audiologic assessment.

At the 4th, 5th, 6th, 8th and 10th year, audiometry is recommended.

Audiometry screening with 6,000 and 8,000 Hz high frequencies is recommended once between 11 through 14 years of age, once between 15 through 17 years of age and once between 18 through 21 years of age

#### **CPT/HCPCS Codes**

CPT 92551 – Screening test, pure tone, air only

CPT 92552 – Pure tone audiometry (threshold); air only

CPT 92558 – Evoked otoacoustic emissions screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions) automated analysis

CPT 92567 – Tympanometry

CPT 92579 – Visual reinforcement audiometry (VRA)

CPT 92582 – Conditioning play audiometry

#### **ICD-10 Codes**

Z00.00 – Routine general medical examination  
Z00.01 – Routine general medical examination  
Z00.110 – Health supervision for newborn under 8 days old  
Z01.111 – Health supervision for newborn 8 to 28 days old  
Z00.121 – Routine infant or child health check  
Z00.129 – Routine infant or child health check  
Z01.110 – Encounter for hearing exam following failed hearing screening  
Z01.10 – Encounter for examination of ears and hearing without abnormal findings  
Z01.118 – Encounter for examination of ears and hearing without other abnormal findings

### **Frequency**

Once within first month after birth, once at 5th, 6th, and 10 years of age and at the 4th through 36th month if there are positive responses to screening questions. Otherwise, at the 7th through the 21st years, if there are positive responses to risk screening questions, the child/adolescent should be referred for audiometry.

## **HEPATITIS B VIRUS INFECTION IN PREGNANCY, SCREENING (Measure 23)**

### **Screening in Pregnant Females**

Screening for hepatitis viral infection during pregnancy is covered for women of “non-grandfathered” plans at the time of their first prenatal visit.

### **Screening in Asymptomatic Adolescents and Adults**

Screening (up to three times per year) is covered for hepatitis B virus (HBV) infection in persons 11 years of age or older at high risk for infection for members of “non-grandfathered” plans.

### **USPSTF Recommendation (Released Jun 2009; Effective on or after Sep 2010)**

The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit. (Grade A)

### **USPSTF Recommendation (Released May 2014; Effective on or after May 2015)**

The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. (Grade B)

### **CPT/HCPCS Codes**

CPT 80055 – Obstetric panel  
CPT 80081 – Obstetric panel (includes HIV testing)  
CPT 87340 – Hepatitis B associated antigen  
HCPCS G0499 - Hepatitis b screening in non -pregnant, high-risk individual

### **ICD-10 Codes**

O09 – O09.40, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies

Z00.00 – General medical exam  
Z00.01 – General medical exam  
Z11.59 – Special screening exam for other specified viral disease  
Z20.2 – Contact with and suspected exposure to infections with a predominantly sexual mode of transmission  
Z20.5 – Venereal disease contact or contact or exposure to other viral diseases  
Z33.1 – Pregnant State  
Z34.00 -Z34.93 - Prenatal visits  
Z36.89 – Encounter for other specified antenatal screening  
Z36.9 – Encounter for antenatal screening, unspecified  
Z57.8 – Personal History of contact with potentially hazardous body fluids  
Z72.51 – Z72.53 – High risk sexual behavior  
Z72.89 – Other problems related to lifestyle  
Z72.9 – Unspecified problems related to lifestyle  
Z73.9 – Unspecified problems related to lifestyle

### **FREQUENCY**

Allowed up to 3 per year for adolescents and adults ages equal to or greater than 11.

### **HEPATITIS C VIRUS SCREENING IN ADULTS (Measure 70)**

*In accordance with Act 598 [Hepatitis C Virus Screening] of the Arkansas legislature for all contracts subject to this law, coverage of Hepatitis C Virus screening during pregnancy is provided at no cost-share.*

Screening for Hepatitis C Virus Infection in Adults is covered one time for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay) for adults between the ages of 18 to 79.

For all fully insured health insurance policies issued in the state of Arkansas and for all self-insured government plans subject to Act 598, testing for hepatitis C during pregnancy is covered at no cost share.

### **USPSTF Recommendation (Released Jun 2013; Effective on or after July 2013) (Re - released March 2020; Effective on or after January 2021)**

The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years. (Grade B)

### **CPT/HCPCS Codes**

CPT 86803 – Hepatitis C antibody  
CPT 87521 – Hepatitis C, amplified probe technique  
HCPCS G0472 - Hepatitis C antibody screening for individual at high risk and other covered indication(s)

### **ICD-10 Codes**

Z00.00 - General medical exam  
Z00.01 – General medical exam  
Z11.59 – Special screening exam for other specified viral diseases  
Z20.5 – Contact or exposure to other viral diseases  
Z57.8 – Personal history of contact with potentially hazardous body fluids  
Z72.89 – Other problems related to lifestyle  
Z72.9 – Other problems related to lifestyle  
Z73.9 – Other problems related to lifestyle

## **FREQUENCY**

Allowed three times per year

## **HIGH BLOOD PRESSURE, SCREENING IN ADULTS (Measure 24)**

Screening for high blood pressure in adults (18 years and older) is covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

### **USPSTF Recommendation (Released Dec 2007; Effective on or after Sep 2010) (Re - released Oct 2015) (Re-released April 2021)**

The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. (Grade A recommendation)

### **CPT/HCPCS Codes**

CPT 99385 – Initial comprehensive preventive medicine, 18 -39 years  
CPT 99386 – Initial comprehensive preventive medicine, 40 -64 years  
CPT 99387 – Initial comprehensive preventive medicine, 65 years & older  
CPT 99395 – Periodic comprehensive preventive medicine, 18 -39 years  
CPT 99396 – Periodic comprehensive preventive medicine, 40 -64 years  
CPT 99397 – Periodic comprehensive preventive medicine, 65 years & older

### **ICD-10 Code**

Z13.6 – Screening for hypertension

### **Frequency**

Allowed once per year.

## **HIGH BLOOD PRESSURE, SCREENING IN INFANTS, CHILDREN & ADOLESCENTS (Measure 53)**

Blood pressure screening for infants and children with specific risk factors for high blood pressure is covered up to age 2 1/2 for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

Blood pressure examination is included in the complete physical examination done routinely after age 2 1/2.

### **HRSA (Bright Futures) Recommendation (Effective Date on or after Sep 2010)**

Infants & children with specific risk factors for high blood pressure should be screened up through age 2½; Blood pressure examination is included in the complete physical examination done routinely after 2½.

### **CPT/HCPCS Codes**

CPT 99381 – Initial comprehensive preventive medicine evaluation, infant up to 1 year  
CPT 99382 – Initial comprehensive preventive medicine evaluation, 1 through 4 years  
CPT 99383 – Initial comprehensive preventive medicine evaluation, 5 through 11 years  
CPT 99384 – Initial comprehensive preventive medicine evaluation, 12 through 17 years  
CPT 99391 – Periodic comprehensive preventive medicine reevaluation, infant up to 1 year  
CPT 99392 – Periodic comprehensive preventive medicine reevaluation, 1 through 4 years  
CPT 99393 – Periodic comprehensive preventive medicine reevaluation, 5 through 11 years  
CPT 99394 – Periodic comprehensive preventive medicine reevaluation, 12 through 17 years

### **ICD-10 Codes**

Z00.00 – Routine general health examination  
Z00.01 – Routine general health examination  
Z00.121 – Routine infant or child health check  
Z00.129 – Routine infant or child health check  
Z13.6 – Screening for hypertension

### **Frequency**

Allowed as part of the well child visits from birth to age 17.

### **HUMAN IMMUNODEFICIENCY VIRUS (HIV), SCREENING (Measure 25)**

Screening for HIV is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) up to four times per year for the following:

- All adolescents and adults aged 15 to 65 years of age.
- Younger adolescents and older adults who are at increased risk for HIV infection (risk factor discussion below).
- For all pregnant women (including those who present in labor who are untested and whose HIV status is unknown).
- All sexually active women.

**USPSTF Recommendation (Released Jul 2005; Effective on or after Sep 2010; Change Mar 2013; Effective, 1 May 2013)**

The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years.

Younger adolescents and older adults who are at increased risk of infection should also be screened. (Grade A)

The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. (Grade A)

**HRSA (Bright Futures) Recommendation**

Adolescents between the ages of 11 -14 who are at increased risk of infection should be screened for HIV. Adolescents aged 15 and older should receive a screening test for HIV.

**HRSA (Women's Health Initiative) Recommendation**

WPSI recommends all adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate at age 13 for adolescents and adult women with an increased risk of HIV infection.

WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status.

**CPT/HCPCS Codes**

CPT 86689 – HTLV or HIV antibody, confirmatory test (e.g., Western Blot)

CPT 86701 – Antibody, HIV -1

CPT 86703 – Antibody, HIV -1 and HIV -2, single assay

CPT 87389 – Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method, HIV -1 antigen(s), with HIV -1 & HIV -2 antibodies antibodies, single result

CPT 87390 – Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method, HIV -1

CPT 87535 – Infectious agent detection by nucleic acid (DNA or RNA); HIV -1, amplified probe

CPT 87806 – Infectious Agent antigen detection by immunoassay with direct optical observation; HIV -1 antigen(s), with HIV-1 and HIV-2 antibodies (Code added 1/1/2015)

CPT 99401 – Preventive medicine counseling, 15 minutes

CPT 99402 – Preventive medicine counseling, 30 minutes

CPT 99403\* – Preventive medicine counseling, 45 minutes

CPT 99404\* – Preventive medicine counseling, 60 minutes

HCPCS G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV and/or HIV2, screening

HCPCS G0433 – Infectious agent antibody detection by enzyme -linked immunosorbent assay (ELISA) Technique, HIV -1 and/or HIV -2 screening

HCPCS G0435 – Infectious agent antibody detection by rapid antibody test, HIV -1 and/or HIV -2 screening

### **ICD-10 Codes**

O09 – O09.40, O09.519, O09.529 – O09.93 – Prenatal visits for high -risk pregnancies

Z00.00 – General medical exam

Z00.01 – General medical exam

Z11.4 – Other specified viral diseases

Z20.2 – Venereal disease contact

Z20.6 – Contact or exposure to other viral diseases

Z33.1 – Pregnant State

Z34.00 – Z34.93 - Prenatal visits

Z71.7 – HIV counseling

Z72.51 – Z72.53 – Problems related to high -risk sexual behavior

Z72.89 – Other problems related to lifestyle

### **Frequency**

4 times per year.

### **Intensive Behavioral Counseling to Promote a Healthy Diet and Physical Activity in Adults with High Risk for Cardiovascular Disease (Measure 18)**

Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults aged 18 years of age or older with cardiovascular disease risk factors (i.e., hypertension, elevated blood pressure, dyslipidemia, mixed or multiple risk factors such as metabolic syndrome or an estimated 10-year CVD risk of 7.5% or greater) are covered for members of “non-grandfathered” plans. Intensive behavioral counseling can be delivered by primary care clinicians or by referral to other specialists (e.g., nutritionists, dietitians, or exercise physiotherapists). This benefit is limited to eight sessions, individual and/or group sessions, per calendar or contract year.

### **USPSTF Recommendation (Released Aug 2014; Effective Jan 2016) (Re -released Nov 2020)**

The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity. (Grade B)

### **CPT/HCPCS Codes**

CPT 97802 – 97803 – Medical Nutrition Therapy (CPT -4 Instructions: Not reported by physicians)

CPT 99385 – Initial Comprehensive Preventive Medicine 19 -39 years

CPT 99386 – Initial Comprehensive Preventive Medicine 40 -64 years  
CPT 99387 – Initial Comprehensive Preventive Medicine 65 years and older  
CPT 99395 – Periodic Comprehensive Preventive Medicine 19 – 39 years  
CPT 99396 – Periodic Comprehensive Preventive Medicine 40 -64 years  
CPT 99397 – Periodic Comprehensive Preventive Medicine 65 years and older  
CPT 99401 – 99404 – Preventive medicine counseling (15, 30, 45, 65 minutes)  
HCPCS G0108 – Diabetes training services  
HCPCS G0109 – Diabetes group training services  
HCPCS G0270 – Medical nutrition therapy  
HCPCS G0271 – Medical nutrition therapy  
HCPCS G0473 – Face -to-Face behavioral counseling for obesity, group (2 -10), 30 minutes  
HCPCS S9140 – Diabetic management program, follow -up visit to non -MD provider  
HCPCS S9141 – Diabetic management program, follow -up to MD provider  
HCPCS S9452 – Nutrition classes, non -physician provider, per session  
HCPCS S9455 – Diabetic management  
HCPCS S9460 – Diabetic management  
HCPCS S9465 – Diabetic management  
HCPCS S9470 – Nutritional counseling, dietician visit

#### **ICD-10 Codes**

E08.00 – E13.9 – Diabetes  
E15-E16.2 – Hypoglycemia  
E66.01 -E66.9 – Obesity  
E71.30 – Disorder of fatty -acid metabolism, unspecified  
E75.21 – E75.22 – Disorders of lipoid metabolism  
E75.240 – E75.249 – Disorders of lipoid metabolism  
E75.3 – Sphingolipidosis, unspecified  
E75.5 – E75.6 – Disorders of lipoid metabolism  
E77.0 – E77.9 – Disorders of lipoid metabolism  
E78.0 – E78.6 – Disorders of lipoid metabolism  
E78.70 – Disorders of lipoid metabolism  
E78.79 – Disorders of lipoid metabolism  
E78.81 – Disorders of lipoid metabolism  
E78.89 – Disorders of lipoid metabolism  
E88.1 – Disorders of lipoid metabolism  
E88.2 – Lipomatosis, not elsewhere classified  
E88.81 – Metabolic  
E88.89 – Other specified metabolic disorders  
I10 – Essential (primary) hypertension  
I11.0 – Hypertensive heart disease with heart failure  
I15.0 – I15.9 – Secondary Hypertension  
I21.01 – I22.9, I24.0 – I24.9 – Heart Disease  
I25.10 – I25.119 – Chronic Ischemic Heart Disease  
I25.700 – I25.812 – Atherosclerosis  
I70.0 – I70.92 – Atherosclerosis  
N26.2 – Page kidney  
R73.01 – R73.02; R73.09 – Impaired glucose tolerance (oral)  
R73.9 – Impaired fasting glucose

Z13.228 – Screening for Other Metabolic Disorder  
Z65.8 – Alcohol Use  
Z65.25 – Z65.29 – Body mass index between 25 -29 adult  
Z68.30 – Z68.39 – Body mass index between 30 -39 adult  
Z68.41 – Z68.45 – Body mass index 40 and over, adult  
Z71.3 – Dietary surveillance and counseling  
Z72.3 – Lack of physical exercise  
Z78.0 – Personal Hx post-menopausal conditions  
Z82.49 – History of Ischemic Heart Disease  
Z83.3 – Personal history endocrine  
Z83.49 – Person history endocrine  
Z86.39 – Metabolic  
Z87.891 – Tobacco use

### **Frequency**

Allowed up to 8 visits a year if medically necessary

### **INTIMATE PARTNER, INTERPERSONAL, AND DOMESTIC VIOLENCE, SCREENING IN WOMEN AND ADOLESCENTS (Measure 66)**

Screening/counseling of women and adolescents for intimate partner, interpersonal, and domestic violence is covered annually for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

### **USPSTF Recommendation (Released Jan 2013) (Grade B); Effective on or after 1 Jan 2014)**

The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence & provide or refer women who screen positive to intervention services.

### **HRSA (WHI) Recommendation (Released Jul 2011; Effective on or after 1 Aug 2012) (Re - released Dec 2021)**

The Women’s Preventive Services Initiative recommends screening adolescents and women for interpersonal and domestic violence, at least annually, and, when needed, providing or referring for initial intervention services.

### **CPT/HCPCS Codes**

CPT 99384 – 99387 – Initial comprehensive preventive medicine E&M of an individual  
CPT 99394 – 99397 – Periodic comprehensive preventive medicine reevaluation & management  
CPT 99401 – Preventive medicine counseling, 15 minutes  
CPT 99402 – Preventive medicine counseling, 30 minutes  
CPT 99403 – Preventive medicine counseling, 45 minutes  
CPT 99404 – Preventive medicine counseling, 60 minutes

### **ICD-10 Codes**

Z00.00 – General medical exam  
Z00.01 – General medical exam  
Z00.121 – Encounter for routine child health examination with abnormal findings  
Z00.129 – Encounter for routine child health examination without abnormal findings  
Z69.11 – Counseling for victim of spousal and partner abuse

### **Frequency**

Allowed once annually

### **LEAD SCREENING IN INFANTS, CHILDREN AND THROUGH AGE 6 (Measure 54)**

The following lead screening is covered for infant and child members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay):

- Screening at the 6-month well-child visit for children who are positive on risk screening questions.
- Routine screening for children through age 6 years from high prevalence areas.
- Selective screening for children through age 6 years from low prevalence areas.

### **HRSA (Bright Futures) Recommendation (Effective Sep 2010)**

Begin screening at the 6 -month well -child visit for children who are positive on risk screening question.

Continue as routine screening for children from high prevalence areas or on Medicaid, and screen selectively children from low prevalence areas and are not on Medicaid. A screening should be done at the 12 month and 24-month visits based on universal screening requirements for individuals with Medicaid or in high prevalence areas.

### **CPT/HCPCS Code**

CPT 83655 – Lead

### **ICD-10 Codes**

Z00.00 – General medical exam  
Z00.01 – General medical exam  
Z00.121 – Routine infant or child health check  
Z00.129 – Routine infant or child health check  
Z13.88 – Screening for chemical poisoning & other contamination

### **Frequency**

No Frequency recommendations

## **SERUM LIPID SCREENING AND STATIN USE FOR PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE (Measures 61)**

Screening for serum lipids (total cholesterol and HDL cholesterol) is covered for members of “non-grandfathered” plans on an annual basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay):

- for adults age 40 to 75 years
- for children who test positive on risk screening questions at age 2, 4, 6 and 8 years
- once for children between the ages of 9 and 11
- once for adolescents between the ages of 17 and 21
- for adolescents who test positive on risk screening questions between 12 and 16 years

The use of a low- to moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) when all of the following criteria are met:

- Member is between 40 to 75 years of age **AND**
- Member has 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking) **AND**
- Member has a calculated 10-year risk of a cardiovascular event of 10% or greater.

**Note:** *Statins addressed in this policy are available through the pharmacy benefit and are not covered under the medical benefit.*

### **USPSTF Recommendations (Released Jun 2008; Effective Sep 2010) (Re -Released Nov 2016) (Re-Released August 2022)**

The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10 -year risk of a cardiovascular event of 10% or greater. (Grade B)

### **HRSA (Bright Futures) Recommendation (Effective Sep 2010) (Published Mar 2014; Effective on or after January 2016) (Re -released March 2017) after January 2016) (Re-Released Mar 2017)**

A fasting lipoprotein profile (total cholesterol, low -density lipoprotein cholesterol, high -density lipoprotein cholesterol, and triglyceride) should be obtained before pubertal onset (once between the ages of 9 -11) and in late adolescence (once between the ages of 17 -21). Screening should be considered for younger children when a history of familial hypercholesterolemia has been identified. Risk assessments should be done at the ages of 2, 4, 6, and 8. A total of 2 fasting lipids should be obtained at these ages for children who test positive on risk screening questions. A risk assessment should also be done at 12 -16 years of age. A total of 2 fasting lipids should be obtained for adolescents between the ages of 12 -16 who test positive to risk screening questions

### **CPT/HCPCS Codes**

CPT 80061 – Lipid panel. This panel must include 1) Cholesterol, serum, total (CPT 82465); 2) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol (CPT 83718); and Triglycerides CPT 84478

CPT 82465 – Cholesterol

CPT 83718 – Lipoprotein, direct measurement, high density cholesterol

### **ICD-10 Codes**

Z00.00 – General medical exam

Z00.01 – General medical exam

Z00.8 – Encounter for other general examination

Z00.121 – Routine infant or child health check

Z00.129 – Routine infant or child health check

Z13.220 – Screening for lipid disorders

### **FREQUENCY**

Annually for Adults for ages 40 -75.

Allowed at age 2, 4, 6, 8; one per year for ages 9 -11; one per year for ages 17 -21; 2 per year for ages 12 -16 who screen positive on risk screening questions.

### **LUNG CANCER SCREENING (Measure 71)**

Annual screening for lung cancer with low-dose computed tomography (LDCT) is covered for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) in adults who met ALL the following criteria:

- Aged 50 to 80; AND
- Have a 20 pack-year smoking history; AND
- Currently smoke or have quit within the past 15 years; AND
- Do not have a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

### **USPSTF Recommendation (Released Jan 2014; Effective on or after Jan 2015) (Re - released March 2021)**

The USPSTF recommends annual screening for lung cancer with low -dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack -year smoking history and currently smoke or have quit in the past 15 years.

Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (Grade B)

### **CPT/HCPCS Codes**

CPT 71271 – Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)

### **ICD-10 Codes**

F17.210 – F17.219 – Nicotine dependence, cigarettes

F17.290 – F17.299 – Nicotine dependence, other tobacco product [pipes, cigars]

Z12.2 – Special screening for malignant neoplasm of the respiratory organs

Z72.0 – Tobacco use

Z87.891 – Personal history of tobacco use, presenting hazards to health

### **FREQUENCY**

Annually

### **MEDIA USE BY CHILDREN & ADOLESCENTS, SCREENING & COUNSELING (Measure 62)**

Screening and counseling for media use by children and adolescents is covered for child and adolescent members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay).

### **HRSA (Bright Futures) Anticipatory Guidance (Effective Jul 2012)**

To screen for media usage, clinicians should ask 2 questions about media use at health supervision visits:

1) How much screen time per day does the child spend?

2) Is there a TV set or Internet connection in the child’s bedroom? Since media potentially influences numerous aspects of child & adolescent health discussion regarding media use may represent the most important area of anticipatory guidance in well child visits.

### **CPT/HCPCS Codes**

CPT 99382 – Initial comprehensive preventive medicine, early childhood (age 1 through 4 years)

CPT 99383 – Initial comprehensive preventive medicine, late childhood (age 5 through 11 years)

CPT 99384 – Initial comprehensive preventive medicine, adolescent age (age 12 through 17 years)

CPT 99385 – Initial comprehensive preventive medicine, adolescent age (age 17 through 21 years)

CPT 99392 – Periodic comprehensive preventive medicine, early childhood (age 1 -4 years)

CPT 99393 – Periodic comprehensive preventive medicine, late childhood (age 5 through 11 years)

CPT 99394 – Periodic comprehensive preventive medicine, adolescent (age 12 through 17 years)

CPT 99395 – Periodic comprehensive preventive medicine, adolescent (age 18 through 21 years)

### **ICD-10 Codes**

Z71.89 – Other specified counseling  
Z71.9 – Counseling, Not Otherwise Specified

### **OBESITY IN ADULTS; SCREENING AND COUNSELING (Measure 33)**

Screening and counseling for obesity in adults is covered for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay).

#### **USPSTF Recommendation (Effective until 1 Jun 2013 when Obesity in Adults becomes effective) (Re -released Sept 2018)**

The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

#### **CPT/HCPCS Codes**

CPT 99385 – 99387 – Initial comprehensive preventive medicine E&M of an individual  
CPT 99395 – 99397 – Periodic comprehensive preventive medicine re -evaluation & management  
CPT 99401 – Preventive medicine counseling; 15 minutes  
CPT 99402 – Preventive medicine counseling; 30 minutes  
CPT 99403 – Preventive medicine counseling; 45 minutes  
CPT 99404 – Preventive medicine counseling; 60 minutes  
HCPCS G0447 – Face -to-face intensive behavioral therapy for obesity, 15 minutes  
HCPCS G0473 – Face -to-face behavioral counseling for obesity group (2 -10), 30 minutes)

#### **ICD-10 Codes**

Z00.00 – General medical exam  
Z00.01 – General medical exam  
Z13.89 – Screening for obesity

#### **Frequency**

Allowed up to 12 visits per year

### **OBESITY IN CHILDREN; SCREENING AND COUNSELING (Measure 33)**

Screening and counseling for obesity in children aged 2 years and older is covered for members of “non-grandfathered” plans on an annual basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Obesity screening by BMI calculation for all children at every well-child visit is covered for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Note: Well-child visits are discussed in policy # 2012046 and recommended at the following intervals: birth, first week after birth, at age 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 2 ½ years, annually until age 10 years and once between 11-14 years, 15-17 years, and 18-21 years.

### **USPSTF Recommendation Children/Adolescents (Released June 2017)**

The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. (Grade B)

### **HRSA (Bright Futures) Anticipatory Guidance (Effective Jul 2012)**

Bright Futures recommends screening with BMI annually beginning at 2 years of age. Recommend referral for counseling to support healthy nutrition and physical activity for children and adolescents 2 years of age and older whose BMI is at or above the 85th percentile for age and sex.

This recommendation applies to children 2 & above

### **CPT/HCPCS Codes**

CPT 99383 -99384 – Initial comprehensive preventive medicine E&M of an individual  
CPT 99393 -99394 – Periodic comprehensive preventive medicine re -evaluation & management  
CPT 99401 – Preventive medicine counseling; 15 minutes  
CPT 99402 – Preventive medicine counseling; 30 minutes  
CPT 99403 – Preventive medicine counseling; 45 minutes  
CPT 99404 – Preventive medicine counseling; 60 minutes  
HCPCS G0447 – Face -to-face intensive behavioral therapy for obesity, 15 minutes  
HCPCS G0473 – Face -to-face behavioral counseling for obesity group (2 10), 30 minutes

### **ICD-10 Codes**

Z00.00 – General medical exam  
Z00.01 – General medical exam  
Z00.121 – Routine infant or child health check  
Z00.129 – Routine infant or child health check  
Z13.89 – Screening for obesity

### **Frequency**

Allowed up to 12 visits per year

### **OSTEOPOROSIS SCREENING IN WOMEN (Measures 34 & 35)**

Screening for osteoporosis is covered for members of “non-grandfathered” plans, no more than once every 2 years, without cost-sharing (i.e., deductible, co-insurance, or co-pay):

- in women aged 65 years of age or older
- In women under the age of 65 years who have an increased risk of osteoporotic fractures. Increased risk is defined as a woman with a risk of fracture equal to or greater than the risk of a 65-year-old white woman with no additional risk (i.e., 9.3%). Risk is determined by the FRAX Score.

The FRAX score does not include risk factors such as the long-term use of certain drugs which have been associated with increased risk of osteoporosis, and the USPSTF recommendation for osteoporosis screening does not specifically address the risk of pharmaceuticals. However, bone mineral density screening of women who are expected to receive long-term use of the following drugs is also covered:

- Oral or injectable glucocorticosteroids (at a dose of prednisolone of 5 mg/day (or equivalent dose of another corticosteroid) for 3 months).
- Heparin if scheduled for >1 month.
- Phenytoin
- Aromatase inhibitors
- Gonadotropin releasing hormone antagonists
- Cyclosporin A
- Tacrolimus
- Parenteral Nutrition

This policy does not apply to individuals with a diagnosis of osteoporosis. Bone Mineral Density testing in individuals with a diagnosis of osteoporosis is handled in policy # 1997054, Bone Mineral Density Testing in Women.

**USPSTF Recommendation (Released Sep 2002; Effective on or after Sep 2010) (Update and Re -Released June 2018)**

The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by formal clinical risk assessment tool. (Grade B)

The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. (Grade B)

**CPT/HCPCS Codes**

CPT 77080 – Dual-energy X -ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

**ICD-10 Code**

Z13.820 – Special screening for osteoporosis

**Frequency**

Allowed no more frequently than every 2 -years for women without a diagnosis of osteoporosis

### **PHENYLKETONURIA SCREENING IN NEWBORNS (Measure 36)**

Screening for phenylketonuria (PKU) in newborns is covered for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay).

#### **USPSTF Recommendation (Released Mar 2008; Effective on or after Sep 2010)**

The USPSTF recommends screening for phenylketonuria (PKU) in newborns. (Grade A)

#### **HRSA (Bright Futures) Recommendation (Effective Date on or after Sep 2010)**

Conduct screening as required by the state. (Arkansas statute requires newborn screening for phenylketonuria; this postnatal test is usually done during the birthing hospitalization).

#### **CPT/HCPCS Code**

CPT 84030 – Phenylalanine (PKU), blood

#### **ICD-10 Code**

Z13.228 – Screening for Phenylketonuria (PKU)

#### **Frequency**

Allowed once per lifetime in first month of life

### **SCREENING FOR HYPERTENSIVE DISORDERS AND PREVENTION OF PREECLAMPSIA IN PREGNANCY (Measure 73)**

#### **Effective January 2025**

Screening for hypertensive disorders in pregnancy with blood pressure measurements is covered for biologic females throughout pregnancy for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

The use of low-dose aspirin (81 mg per day) when prescribed by a health care provider with prescribing authority is covered as a preventive medication after 12 weeks gestation in biologic females who are high risk for preeclampsia for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

#### **Effective January 2019 – December 2024**

Screening for preeclampsia in pregnant women with blood pressure measurements is covered throughout pregnancy for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

The use of low-dose aspirin (81 mg per day) when prescribed by a health care provider with prescribing authority is covered as a preventive medication after 12 weeks gestation in women who are high risk for preeclampsia for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

**USPSTF Recommendation (Released Sep 2014; Effective on or after Sep 2015)**

The USPSTF recommends screening for hypertensive disorders in pregnancy with blood pressure measurements is covered for biologic females throughout pregnancy.

The use of low -dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in biologic females who are at high risk for preeclampsia. (Grade B)

**CPT/HCPCS Code**

CPT 99384 – Initial comprehensive preventive medicine exam, age 12 through 17 years

CPT 99385 – Initial comprehensive preventive medicine exam, age 18 through 24 years

CPT 99386 – Initial comprehensive preventive medicine exam, age 40 through 64 years

**Frequency**

Allowed once per specialty with ≤ 3-year break between visits

**CPT/HCPCS Code**

CPT 99394 – Periodic comprehensive preventive medicine reevaluation and management, adolescent age 12 through 17 years

CPT 99395 – Periodic comprehensive preventive medicine reevaluation and management, age 18 through 39 years

CPT 99396 – Periodic comprehensive preventive medicine reevaluation and management, age 40 through 64 years

CPT 99401 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

CPT 99402 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

CPT 99403 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

CPT 99404 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

**ICD-10 Codes**

O09 – O09.40 - Supervision of pregnancy with...

O09.519 - Supervision of elderly primigravida, unspecified trimester

O09.529 – O09.93 - Supervision of...

Z00.00 - Encounter for general adult medical examination without abnormal findings

Z00.01 - Encounter for general adult medical examination with abnormal findings

Z33.1 - Pregnant state, incidental

Z34.00 - Z34.93 - Encounter for supervision of normal first pregnancy...

### **Frequency**

Allowed as part of prenatal visits pregnancy (40 weeks)

### **PREGNANCY, SCREENING, IN SEXUALLY ACTIVE FEMALES WITHOUT CONTRACEPTION, LATE MENSES, OR AMENORRHEA (Measure 57)**

Pregnancy screening with urine human chorionic gonadotropin testing is covered for the following female members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay):

- Sexually active females aged 11-21; AND
- Do not practice contraception, have late menses, or have amenorrhea.

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

HRSA (Bright Futures) recommends screening for pregnancy with urine human chorionic gonadotrophin in sexually active females who do not practice contraception, who have late menses, or amenorrhea, ages 11 to 21.

### **CPT/HCPCS Codes**

CPT 81025 – Urine pregnancy test, by visual color comparison methods

CPT 84703 – Gonadotrophin, chorionic (hCG), qualitative

### **ICD-10 Codes**

O09 – O09.40, O09.519, O09.529, O09.611 – O09.93 – Prenatal visits for high-risk pregnancies

Z00.00 – General Medical Exam

Z00.01 – General Medical Exam

Z33.1 – Pregnant state, incidental

Z34.00 – Z34.93 - Prenatal visits

### **Frequency**

Allowed up to twice per year.

### **PREVENTION OF FALLS IN COMMUNITY DWELLING ADULTS 65 & OLDER (Measure 67)**

Physical Therapy or exercise to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls is covered once per year, subject to the limitations set forth in the member benefit certificate for rehabilitative services for members of “non-grandfathered” plans without cost-sharing (i.e., deductible, co-insurance, or co-pay).

**USPSTF RECOMMENDATION (Released May 2012; Effective on or after 1 Jun 2013) (Re - Released April 2018)**

The USPSTF recommends exercise interventions to prevent falls in community -dwelling adults 65 years or older who are at increased risk for falls. (Grade B)

**CPT CODES**

CPT 97110 – Therapeutic exercises to develop strength & endurance, range of motion & flexibility

CPT 97112 – Neuromuscular re -education for movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

CPT 97116 – Gait training (includes stair climbing)

CPT 97750 – Physical performance test or measurement (e.g., musculoskeletal, functional capacity)

HCPCS G0159 – Services performed by a qualified PT in the home health setting, in the establishment or delivery of a safe & effective PT maintenance program

HCPCS S9131 – Physical Therapy in the home, per diem

**ICD-10 Code**

Z91.81 – History of fall or at risk of falling

**Frequency**

Allowed once per year.

**PREVENTION OF SKIN CANCER; COUNSELING PERSONS 10 -24 (Measure 68)**

Behavioral counseling regarding exposure to ultraviolet radiation to reduce risk for skin cancer is covered for members of “non-grandfathered” plans with fair skin aged 6 months to 24 years. Brief counseling may be delivered by primary care clinicians. This benefit is limited to 1 session per calendar or contract year.

**USPSTF Recommendation (Released May 2012; Effective on or after 1 Jun 2013) (Update and Re -Released March 2018)**

The USPSTF recommends counseling young adults, adolescents, children and parents of young children about minimizing their exposure to ultraviolet radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk. (Grade B)

**CPT/HCPCS Codes**

CPT 99381 – Initial comprehensive preventive medicine exam, new patient; infant (age younger than 1 year)

CPT 99382 – Initial comprehensive preventive medicine exam, new patient; infant (age 1 through 4 years)

CPT 99383 – Initial comprehensive preventive medicine exam, age 5 through 11 years

CPT 99384 – Initial comprehensive preventive medicine exam, age 12 through 17 years

CPT 99385 – Initial comprehensive preventive medicine exam, age 18 through 24 years  
CPT 99391 – Periodic comprehensive preventive medicine exam, established patient (age younger than 1 year)  
CPT 99392 – Periodic comprehensive preventive medicine exam, established patient (age 1 through 4 years)  
CPT 99393 – Periodic comprehensive preventive medicine exam, age 5 through 11 years  
CPT 99394 – Periodic comprehensive preventive medicine exam, age 12 through 17 years  
CPT 99395 – Periodic comprehensive preventive medicine exam, age 18 through 24 years

### **ICD-10 Codes**

Z00.00 – Routine general medical examination  
Z00.01 – Routine general medical examination  
Z00.8 – Encounter for other general examination  
Z00.121 – Routine infant or child health check  
Z00.129 – Routine general medical examination

### **Frequency**

Allowed once per year.

### **RH INCOMPATIBILITY SCREENING (Measure 37 & 38)**

Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care is covered for up to two per year for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Repeat Rh (D) antibody testing for all unsensitized Rh (D)-negative women is covered at 24-28 weeks gestation (unless the biological father is known to be Rh (D)-negative) for up to two per year for members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

### **USPSTF Recommendations (Released Feb 2004; Effective Sep 2010)**

The USPSTF strongly recommends Rh(D) blood typing & antibody testing for all pregnant women during their 1st pregnancy visit for pregnancy related care. (Grade A)

The USPSTF recommends repeated Rh(D) blood typing & antibody testing for all unsensitized Rh(D) negative women at 24 -28 weeks gestation, unless the father is known to be Rh(D) negative. (Grade B)

### **CPT/HCPCS Codes**

CPT 80055 – Obstetrical Panel  
CPT 86901 – Blood typing; Rh (d)

### **ICD-10 Codes**

O09 – O09.40, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies

Z33.1; Z34.00 – Z34.93 - Prenatal visits

### **Frequency**

Allowed twice during pregnancy

### **SEXUALLY TRANSMITTED INFECTIONS (STI's); BEHAVIORAL COUNSELING TO PREVENT (Measure 39)**

Behavioral counseling to prevent Sexually Transmitted Infections (STIs) is covered for sexually active adolescent members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Behavioral counseling to prevent Sexually Transmitted Infections (STIs) is covered for adult members (at increased risk for STIs) of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Increased risk for Sexually Transmitted Infection is defined as:

- adults with current STI infections;
- adults who have multiple current sexual partners;
- adults from communities with a high population of STIs; OR
- all sexually active patients in non-monogamous relationships.

Six counseling sessions will be allowed per year per member.

Counseling to prevent Sexually Transmitted Infections (STIs) is covered annually for all sexually active women members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay) (HRSA Recommendation) (**EFFECTIVE 8/01/2012**).

### **USPSTF Recommendation (Released Oct 2008; Effective on or after Sep 2010)**

The USPSTF recommends high intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. (Grade B)

### **HRSA (WHI) Recommendation (Released Jul 2011; Effective on or after 1 Aug 2012)**

The Women’s Preventive Service Initiative recommends directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for STIs.

### **BRIGHT FUTURES Recommendation**

Bright Futures recommends screening for STIs in all sexually active adolescents.

### **CPT/HCPCS Codes**

CPT 99401 – Preventive medicine counseling; 15 minutes  
CPT 99402 – Preventive medicine counseling; 30 minutes  
CPT 99403\* – Preventive medicine counseling, 45 minutes  
CPT 99404\* – Preventive medicine counseling, 60 minutes  
HCPCS G0445 – High intensity behavioral counseling to prevent STI; face -to-face, individual, includes: education, skills training & guidance on how to change sexual behavior; performed semi -annually, 30 min.

### **ICD-10 Codes**

Z71.7 – Human immunodeficiency virus counseling  
Z71.89 – Other specified counseling  
Z72.51 – Z72.53 – Problems related to high -risk sexual behavior

### **Frequency**

Up to 6 visits a year if medically necessary

### **SYPHILIS SCREENING (Measures 41 & 42)**

Screening for Syphilis is covered for members of “non-grandfathered” plans on an annual basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay) for:

- Persons at risk for Syphilis infection
- All pregnant women

### **USPSTF Recommendation (Released Jul 2004 & May 2009; Effective on or after Sep 2010)**

The USPSTF strongly recommends that clinicians screen all persons at increased risk for syphilis infection. (Grade A)

The USPSTF recommends that clinicians screen all pregnant women for syphilis infection. (Grade A).

### **HRSA Recommendation (Bright Futures)**

Bright Futures recommends screening for syphilis in all adolescents who are sexually active and positive for high risk.

### **CPT/HCPCS Codes**

CPT 80055 – Obstetric panel  
CPT 86592 – Syphilis test, qualitative  
CPT 86780 – Antibody, Treponema pallidum

### **ICD-10 Codes**

O09.00 – O09.40, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies

Z00.00 – General Medical Exam  
Z00.01 – General Medical Exam  
Z11.3 – Screening for sexually transmitted infections  
Z34.00 – Z34.93 – Prenatal visits  
Z33.1 – Pregnant state, incidental  
Z72.51 – Z72.53 – High Risk Sexual behavior

## **FREQUENCY**

Allowed once per year for women & adolescents who are sexually active and at high risk

Allowed for pregnant women or adolescents at the initial visit for the pregnancy, and again during the 3rd trimester and at delivery if the person has continued high risk behavior

## **TOBACCO USE, SCREENING, COUNSELING AND INTERVENTIONS (Measures 43 & 44)**

Screening for tobacco use including counseling and tobacco cessation interventions is covered for adult members of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay). Screening for tobacco use including augmented, pregnancy-tailored counseling and interventions is covered for pregnant members (who smoke) of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

Screening for tobacco use including education and brief counseling to prevent the initiation of tobacco use is covered for school-aged children and adolescent members (greater than 5 years of age) of “non-grandfathered” plans, without cost-sharing (i.e., deductible, co-insurance, or co-pay). (Bright Futures and USPSTF Recommendations)

### **USPSTF Recommendation (Released April 2009; Effective on or after Sep 2010)**

The USPSTF recommends that all clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (Grade A)

The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented pregnancy -tailored counseling for those who smoke. (Grade A)

The USPSTF recommends that all clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school -aged children and adolescents. (Grade B) (Effective 08/2014, Revised April 2020)

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Bright Futures recommends that health care professionals screen for tobacco use & tobacco smoke exposure, encourage tobacco use cessation, and provide tobacco use cessation strategies & resources at most visits for adolescents ages 11 through 21.

## **CPT/HCPCS Codes**

CPT 99406 – Smoking and tobacco use cessation counseling visit, intermediate, 3 -10 minutes

CPT 99407 – Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes  
(Bright Futures recommends these codes when reporting counseling for tobacco use by parents)

**ICD-10 Codes**

F17.200 – F17.201, F17.210 – F17.211, F17.220 – F17.221 – Tobacco dependence  
F17.290; F17.291 – Nicotine dependence, other tobacco product  
O09 – O09.4, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies  
O99.331 – O99.335 – Tobacco use disorder complicating pregnancy  
Z33.1 – Pregnant State  
Z34.00 – Z34.93 - Prenatal visits  
Z71.89 – Other specified counseling  
Z77.22 – Other specified personal history presenting hazards to health  
Z87.891 – History of tobacco use

**FREQUENCY**

No Frequency limit.

**TUBERCULOSIS, SCREENING (Measure 55)**

Tuberculosis screening is covered for members of all ages who are assessed to be at an increased risk for tuberculosis.

**HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Begin selective screening for tuberculosis with the tuberculin skin test for infants, children, and adolescents who are at increased risk based on risk screening questions, at the first month well - child visit and continue through adolescence.

**CPT/HCPCS Codes**

CPT 86480 – Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon  
CPT 86580 – Skin test, tuberculosis, intradermal

**ICD-10 Codes**

Z00.00 – Encounter for general adult medical examination without abnormal findings  
Z00.01 – Encounter for general adult medical examination with abnormal findings  
Z11.1 – Encounter for screening for respiratory tuberculosis  
Z11.7 – Encounter for testing for latent tuberculosis infection  
Z20.1 – Contact with and (suspected) exposure to tuberculosis

**Frequency**

No Frequency parameters

**VISUAL IMPAIRMENT, SCREENING IN CHILDREN (Measure 45)**

Visual screening to detect amblyopia, strabismus and defects in visual acuity is covered in children 5 years of age or younger for members of “non-grandfathered” plans on an annual basis, without cost-sharing (i.e., deductible, co-insurance, or co-pay).

**USPSTF Recommendation (Released May 2004; Effective on or after Sep 2010)**

The USPSTF recommends vision screening for all children at least once between the ages of 3 & 5 years, to detect the presence of amblyopia or its risk factors (Grade B)

**HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument based screening may be used to assess risk in ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age.

**CPT/HCPCS Codes**

CPT 99173 – Screening test of visual acuity, quantitative, bilateral  
CPT 99174 – Ocular photoscreening, interpretation, report, bilateral  
CPT 99177 – Instrument -based ocular screening (eg, photo screening, automat ed-refraction), bilateral, with on-site analysis

**ICD-10 Codes**

Z00.121, Z00.129 – Routine infant or child health check, 29 days or older  
Z01.00, Z01.01 – Examination of eyes and vision  
Z13.5 – Special screening for “other eye conditions”, including congenital anomaly of eye

**WELL CHILD VISITS, NEWBORN, INFANT, CHILDREN, ADOLESENTS, & AGES 18 -21 (Measure 46)**

*For contracts subject to Arkansas Act 316, SCREENING FOR DEPRESSION OF BIRTH MOTHERS, [individual, blanket, or any group plan, policy, or contract for healthcare services issued, renewed, or extended in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self -insured governmental or church plan in this state (all fully -insured and state government such as ASE/PSE, ASP)] coverage shall be provided for depression screening for birth mothers at the time of birth or within the first six weeks of birth . For all contracts not subject to Ark law [e.g. federally chartered contracts such as ERISA groups, Federal Employee Health Benefit Program, and Medicare Advantage], these benefits will be provided as directed by PPACA.*

Well-child visits are covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance, or co-pay) at the following intervals: Birth, first week after birth, at age 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 2 ½ years, 3 years, and then annually through the age of 21 years.

\*Note: Well-child visits include, but are not limited to services for developmental surveillance, psychosocial and behavioral assessments, depression and maternal depression screening, measurements, vital signs, risk assessment for Hepatitis B virus, and physical examination.

### **HRSA (Bright Futures) Recommendation (Effective on or after Sep 2010)**

Bright Futures recommends well child visits at birth, first week after birth, at age 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 2½ years, 3 years, 4 years, 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, and continue annually through age of 21 years.

(Coverage for these visits is similar to those required by Arkansas Statute, except for the 18 -21 years)

\*Note: Well -child visits include, but are not limited to services for developmental surveillance, psychosocial and behavioral assessments, depression and maternal depression screening, measurements, vital signs, risk assessment for Hepatitis B virus, and physical examination.

### **CPT/HCPCS**

CPT 99381 – Initial comprehensive preventive medicine exam, infant  
CPT 99382 – Initial comprehensive preventive medicine early childhood (age 1 through 4 years)  
CPT 99383 – Initial comprehensive preventive medicine late childhood (age 5 through 11 years)  
CPT 99384 – Initial comprehensive preventive medicine adolescent age (age 12 through 17 years)  
CPT 99385 – Initial comprehensive preventive medicine 18 -39 years  
CPT 99391 – Periodic comprehensive preventive medicine, infant  
CPT 99392 – Periodic comprehensive preventive medicine, age 1 through 4 years  
CPT 99393 – Periodic comprehensive preventive medicine late childhood (age 5 through 11 years)  
CPT 99394 – Periodic comprehensive preventive medicine adolescent (age 12 through 17 years)  
CPT 99395 – Periodic comprehensive preventive medicine 18 -39  
CPT 96127 – Brief emotional/behavioral assessment (eg, depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument  
CPT 96160 – Administration of patient focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument  
CPT 96161 – Administration of caregiver focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

### **ICD-10 Codes**

Z00.00 – General Health Exam  
Z00.01 – General Medical Exam  
Z00.8 – Encounter for other general examination  
Z00.121 – Routine infant or child health check, infant ages 29 days old and older  
Z00.129 – Routine infant or child health check, infant ages 29 days old and older

Z00.110 – Health supervision for newborn under 8 days old  
Z00.110 – Health supervision for newborn under 8 days old

Z00.111 – Health supervision for newborn 8 -28 days old

Z13.32 – Encounter for screening for maternal depression

Z71.89 – Other specified counseling

### **Frequency**

Allowed as part of the well child visits from birth to age 21.

### **WELL WOMAN VISIT FOR ADOLESCENT AND ADULT WOMEN (Measure 58)**

Annual preventive care visits (including pre-pregnancy, prenatal, postpartum, and interpregnancy visits) are covered for members of “non-grandfathered” plans for adolescent and adult women 11 years of age or older. One visit per year is covered without cost sharing (i.e., deductible, co-insurance, or co-pay).

*\*Note: Well-woman visits include, but are not limited to, services for counseling/anticipatory guidance/risk factor reduction interventions, ordering of lab/diagnostic interventions, urinary incontinence screening, obesity prevention counseling, vital signs, and physical examination.*

*\*Note: Preconception, prenatal, and postpartum care visits are covered for covered dependent pregnant daughters of any age.*

### **HRSA (WHI) Recommendation (Released Jul 2011; Effective on or after 1 Aug 2012) (Released December 2017) (Re -released Nov 2021)**

WPSI recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors.

These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman’s age, health status, reproductive health needs, pregnancy status, and risk factors. Well -women visits also include prepregnancy, prenatal, postpartum and interpregnancy visits.

This well -woman visit should, where appropriate, include other preventive services listed in this set of guidelines as well as others referenced in section 2713 (of the Patient Protection and Accountable Care Act of 2010).

### **HRSA (WHI) Recommendation (Released December 2017)**

The Women’s Preventive Services Initiative recommends screening women for urinary incontinence annually.

Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. The Women's Preventive Services Initiative recommends referring women for further evaluation and treatment if indicated.

### **HRSA (WHI) Recommendation (Released January 2022)**

WPSI recommends counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5 -29.9 kg/m<sup>2</sup>) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.

### **CPT/HCPCS Codes**

CPT 59425 – Antepartum care only, 4 -6 visits  
CPT 59426 – Antepartum care, 7 or more visits  
CPT 59430 – Postpartum care only (separate procedure)  
CPT 99383 – Initial comprehensive preventive medical exam, 5 -1  
CPT 99384 – Initial comprehensive preventive medical exam, 12 -17  
CPT 99385 – Initial comprehensive preventive medical exam, 18 -39  
CPT 99386 – Initial comprehensive preventive medical exam, 40 -64  
CPT 99387 – Initial comprehensive preventive medical exam, 65 years and older  
CPT 99393 – Periodic comprehensive preventive medicine exam, 5 -11  
CPT 99394 – Periodic comprehensive preventive medicine exam, 12 -17  
CPT 99395 – Periodic comprehensive preventive medicine exam 18 -39  
CPT 99396 – Periodic comprehensive preventive medicine exam, 40 -64  
CPT 99397 – Periodic comprehensive preventive medicine exam 65 years & older  
CPT 99459 – Pelvic examination (List separately in addition to code for primary procedure)  
HCPCS G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination  
HCPCS G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPS, initial visit)  
HCPCS G0439 – Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit  
HCPCS S0610 – Annual gynecological examination, new patient  
HCPCS S0612 – Annual gynecological exam

### **ICD-10 Codes**

O09 – O09.4 0, O09.519, O09.529 – O09.93 – Prenatal visits for high-risk pregnancies  
Z00.00 – General Medical Exam  
Z00.01 – General Medical Exam  
Z13.89 – Encounter for screening for other disorder (Encounter for screening for genitourinary disorders)  
Z33.1 – Pregnant State  
Z34.00 – Z34.93 – Prenatal visits  
Z01.419 – Encounter for gynecological examination (general) (routine) without abnormal findings

### **Frequency**

Allowed once annually but may require more visits to complete screening & counseling.  
Antepartum care could occur twice in one year.

## **PREVENTION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, PREEXPOSURE PROPHYLAXIS (Measure 77)**

Preexposure prophylaxis (PrEP) with antiretroviral therapy for persons who are at high risk of HIV acquisition is covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay). (NOTE: Please check the pharmacy benefit for specifics related to coverage of oral antiretroviral therapy medications. Oral antiretroviral therapy is not covered under the medical benefit.)

The following services are covered for members of “non-grandfathered” plans, without cost sharing (i.e., deductible, co-insurance or co-pay) for individuals at high risk of HIV acquisition who are receiving preexposure prophylaxis (PrEP) with effective antiretroviral therapy.

### ***\*\*Frequency of testing will be per CDC guidance\*\****

- HIV testing
- Screening for Hepatitis B
- Screening for Hepatitis C
- Screening for Chlamydia
- Screening for Gonorrhea
- Screening for Syphilis
- Creatinine with Calculated Estimated Creatine Clearance (eCrCl)
- Pregnancy testing for females (xx chromosome)
- Trichomonas testing for females (xx chromosome)
- Adherence/Behavioral Counseling with office visit

### **USPSTF Recommendation (Released June 2019)**

The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. (Grade A)

### **CPT/HCPCS Codes**

CPT 81025 – Urine pregnancy test, by visual color comparison methods

CPT 82565 – Creatinine; blood

CPT 82570 – Creatinine; other source

CPT 82575 – Creatinine; clearance

CPT 86592 – Syphilis test, non treponemal antibody; qualitative (eg, VDRL, RPR, ART)

CPT 86689 – Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)

CPT 86701 – Antibody; HIV 1

CPT 86702 – Antibody; HIV 2

CPT 86703 – Antibody; HIV 1 and HIV 2, single result

CPT 86803 – Hepatitis C antibody

CPT 87270 – Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis

CPT 87320 – Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme linked immunosorbent assay [ELISA], fluorescence immunoassay

[FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis

CPT 87340 – Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)

CPT 87389 – Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV -1 antigen(s), with HIV -1 and HIV -2 antibodies, single result

CPT 87390 – Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV -1

CPT 87490 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique

CPT 87491 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique

CPT 87521 – Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique, includes reverse transcription when performed

CPT 87535 – Infectious agent detection by nucleic acid (DNA or RNA); HIV 1, amplified probe technique, includes reverse transcription when performed

CPT 87590 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique

CPT 87591 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique

CPT 87592 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification

CPT 87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

CPT 87801 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

CPT 87806 – Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; HIV -1 antigen(s), with HIV -1 and HIV -2 antibodies

CPT 87808 – Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis

CPT 87810 – Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Chlamydia trachomatis

CPT 87850 – Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Neisseria gonorrhoeae

CPT 99211 – Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

CPT 99212 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10 -19 minutes of total time is spent on the date of the encounter.

CPT 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of

medical decision making. When using time for code selection, 20 -29 minutes of total time is spent on the date of the encounter.

CPT 99214 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30 -39 minutes of total time is spent on the date of the encounter.

CPT 99215 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40 -54 minutes of total time is spent on the date of the encounter.

CPT 99401 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

CPT 99402 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes

CPT 99403 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

CPT 99404 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

HCPCS G0432 – Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv 1 and/or hiv 2, screening

HCPCS G0433 – Infectious agent antibody detection by enzyme linked immunosorbent assay (elisa) technique, hiv 1 and/or hiv 2, screening

HCPCS G0435 – Infectious agent antibody detection by rapid antibody test, hiv 1 and/or hiv 2, screening

HCPCS G0445 – High intensity behavioral counseling to prevent sexually transmitted infection; face to face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semiannually, 30 minutes

HCPCS G0472 – Hepatitis c antibody screening, for individual at high risk and other covered indication(s)

HCPCS G0499 – Hepatitis b screening in non-pregnant, high-risk individual includes hepatitis b surface antigen (hbsag), antibodies to hbsag (anti hbs) and antibodies to hepatitis b core antigen (anti hbc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive hbsag result

HCPCS J0738 – Injection, lenacapavir, 1 mg, fda approved prescription, only for use as hiv pre exposure prophylaxis (not for use as treatment for hiv)

HCPCS J0739 – Injection, cabotegravir, 1 mg fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)

HCPCS Q0521 – Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription

HCPCS S3645 – Hiv 1 antibody testing of oral mucosal transudate

### **ICD-10 Codes**

T76.51XA – Adult forced sexual exploitation, suspected, initial encounter

T76.51XD – Adult forced sexual exploitation, suspected, subsequent encounter

T76.52XA – Child sexual exploitation, suspected, initial encounter

T76.52XD – Child sexual exploitation, suspected, subsequent encounter

W46.0XXA – Contact with hypodermic needle, initial encounter

W46.0XXD – Contact with hypodermic needle, subsequent encounter

W46.1XXA – Contact with contaminated hypodermic needle, initial encounter

W46.1XXD – Contact with contaminated hypodermic needle, subsequent encounter  
Z00.00 – General Medical Exam  
Z00.01 – General Medical Exam  
Z04.81 – Encounter for examination and observation of victim following forced sexual exploitation  
Z11.3 – Encounter for screening for infections with a predominantly sexual mode of transmission  
Z11.4 – Encounter for screening for human immunodeficiency virus [HIV]  
Z11.59 – Encounter for screening for other viral diseases  
Z20.2 – Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission  
Z20.5 – Contact with and (suspected) exposure to viral hepatitis  
Z20.6 – Contact with and (suspected) exposure to human immunodeficiency virus [HIV]  
Z20.828 – Contact with and (suspected) exposure to human immunodeficiency virus [HIV]  
Z20.89 – Contact with and (suspected) exposure to other communicable diseases  
Z20.9 – Contact with and (suspected) exposure to an unspecified communicable disease  
Z57.8 – Occupational exposure to other risk factors  
Z70.9 – Sex counseling, unspecified  
Z71.7 – Human immunodeficiency virus [HIV] counseling  
Z71.89 – Other specified counseling  
Z72.51 – High risk heterosexual behavior  
Z72.52 – High risk homosexual behavior  
Z72.53 – High risk bisexual behavior  
Z72.89 – Other problems related to lifestyle  
Z72.9 – Problem related to lifestyle, unspecified  
Z73.9 – Problem related to life management difficulty, unspecified  
Z77.21 – Contact with and (suspected) exposure to potentially hazardous body fluids  
Z77.9 – Other contact with and (suspected) exposures hazardous to health  
Z79.899 – Other long term (current) drug therapy

### Frequency

Allowed every three (3) months for ages ≥ 12 and older

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## II. CLINICAL TRIAL REQUIREMENTS FOR NON-GRANDFATHERED PLANS

Coverage is provided for routine patient costs that include all items and services typically covered for a qualified individual with the same diagnosis who is not enrolled in a clinical trial. These services include evaluation and management services, drug administration, medical or surgical services related to a device, lab tests or imaging done at a frequency consistent with signs and symptoms and other standards of care for the diagnosis, or treatment type, and prevention of complications and reasonable and necessary care arising from the use of an investigational service.

Services excluded from coverage include:

- The investigational item, device, drug or service, itself; AND
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, including genetic testing to determine the anticipated response to a particular pharmaceutical; OR
- A service is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**IN-NETWORK PROVIDERS:** If one or more participating providers is participating in a clinical trial the Plan may require that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

**OUT-OF-NETWORK PROVIDERS:** The law does not require a health plan of health insurance issuer to provide benefits for routine patient care services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan or coverage.

**DEFINITIONS:**

**Qualified Individual:** an individual who is a participant or beneficiary in a health plan who meets the following conditions:

- The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.
- The referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions stated in the description field; OR
- The participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions stated in the Description field.

**Approved Clinical Trial:**

Generally, 'approved clinical trial' means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition AND is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- The National Institutes of Health (NIH)
- The Centers for Disease Control and Prevention
- The Agency for Health Care Research and Quality (AHRQ)
- The Centers for Medicare and Medicaid Services
- Cooperative group or center of any of the entities described in clauses (i) through (iv) of the Department of Defense or the Department of Veterans Affairs
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
- Any of the following if the conditions described in "Conditions for Departments' (below) are met:
  - The Department of Veterans Affairs

- The Department of Defense
- The Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

#### **Conditions for Departments**

The conditions described in this paragraph for a study or investigation by a Department, are that the study or investigations have been reviewed and approved through a system of peer review that the Secretary determines:

- To be comparable to the system of peer review of studies and investigations used by the NIH, AND
- Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

#### **Life-Threatening Condition:**

In this law 'life-threatening condition' is defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

### **III. OTHER PREVENTIVE SERVICES**

#### **ACIP Immunizations Recommendations (Measure 47)**

An immunization that does not fall under one of the exclusions in the Certificate of Coverage is considered covered without cost sharing (i.e., deductible, co-insurance, or co-pay) by Health Plans when the immunization has received FDA approval and has an ACIP recommendation published in the Morbidity & Mortality Weekly Report (MMWR) of the Centers for Disease Control and Prevention (CDC). Implementation will typically occur within 60 days after publication in the MMWR.

#### **Immunization Administration Codes:**

CPT 90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/ toxic component (This code is effective 1/1/2011)

CPT 90461 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/ toxic component (List separately in addition to code for primary procedure) (This code is effective 1/1/2011)

CPT 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

CPT 90472 – Immunization administration (add)

CPT 90473 – Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

CPT 90474 – Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

CPT 90480 – Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV -2) (coronavirus disease [COVID -19]) vaccine, single dose

CPT 90481 – Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS CoV 2) (coronavirus disease [COVID 19]) vaccine; each additional component administered (List separately in addition to code for primary procedure)

HCPCS G0008 – Administration of influenza virus vaccine

HCPCS G0009 – Administration Pneumococcal

HCPCS G0010 – Administration of hepatitis B vaccine

**Immunization /Vaccine Codes:**

CPT 90380 – Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use; For all infants younger than 8 months born during or entering their first RSV season, and for infants and children aged 8 -19 months who are at increased risk of severe RSV disease entering their second RSV season (Effective 8/25/2023)

CPT 90381 – Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use; For all infants younger than 8 months born during or entering their first RSV season, and for infants and children aged 8 -19 months who are at increased risk of severe RSV disease entering their second RSV season. (Effective 8/25/2023)

CPT 90382 – Respiratory syncytial virus, monoclonal antibody, seasonal dose, 0.7 mL, for intramuscular use

CPT 90396 – Varicella -zoster immune globulin, human, for intramuscular use; (ICD10 code is Z23)

CPT 90587 – Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use (For ages 9 -16 years having evidence of a previous dengue infection and living in areas where dengue is endemic)

CPT 90619 – Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY -TT), for intramuscular use

CPT 90620 – Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use. (ICD10 code is Z23) (Effective for group renewal on or after June 12, 2016.

CPT 90621 – Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use. (ICD10 code is Z23) (Effective for group renewal on or after June 12, 2016).

CPT 90623 – Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y tetanus toxoid carrier, and Men B FHbp, for intramuscular use (Effective 10/26/2023)

CPT 90624 - Meningococcal pentavalent vaccine, Men B 4C recombinant proteins and outer membrane vesicle and conjugated Men A, C, W, Y diphtheria toxoid carrier, for intramuscular use (Effective April 16, 2026)

CPT 90630 – Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use. (ICD10 code is Z23)

CPT 90632 – Hepatitis A vaccine, adult, for intramuscular use; (ICD10 code is Z23)

CPT 90633 – Hepatitis A vaccine, pediatric/adolescent dosage -2 dose schedule, for intramuscular use (ICD10 code is Z23)

CPT 90636 – Hepatitis A and hepatitis B vaccine (HepA -HepB), adult dosage, for intramuscular use. Limited to 4 units per lifetime. (ICD10 code is Z23)

CPT 90644 – Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine, tetanus toxoid conjugate (Hib -MenCY -TT), (4 dose schedule) Note: coverage for 90644 is limited to infants and children ages 6 weeks to 18 months (effective Jan 2013). (ICD10 code is Z23)

CPT 90647 – Hemophilus influenza b vaccine (Hib), PRP -OMP conjugate (3 dose schedule), for intramuscular use (ICD10 code is Z23) (Age <=18)

CPT 90648 – Hemophilus influenza b vaccine (Hib), PRP -T conjugate (4 dose schedule), for intramuscular use (Appropriate ICD9 code is V03.81) (Appropriate (ICD10 code is Z23) (Age <=18)

CPT 90649 – Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use *Note: coverage for 90649 is limited to adolescents and adults ages 9 – 26 and some adults aged 27 -45 who are not adequately vaccinated.* (ICD10 code is Z23)

CPT 90650 – Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use *Note: coverage for 90650 is limited to adolescents and adults ages 9 – 26 and some adults aged 27 -45 who are not adequately vaccinated.* (ICD10 code is Z23)

CPT 90651 – Human Papilloma virus (HPV) vaccine, types 6, 11, 6, 18, 31, 33, 45, 52, 58 nonvalent, 3 dose schedule, for intramuscular use *Note: coverage for 90651 is limited to adolescents and adults ages 9 – 26 and some adults aged 27 -45 who are not adequately vaccinated.* (Appropriate ICD10 code is Z23)

CPT 90653 – Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use. Ages 65 years and older (Effective 8/1/2016)

CPT 90655 – Influenza virus vaccine, split virus, preservative free, when administered to children 6 -35 months of age, 0.25 mL dosage for intramuscular use (ICD10 code is Z23) (Age <=3)

CPT 90656 – Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, 0.5 mL dosage for intramuscular use (ICD10 code is Z23) (Age <=3)

CPT 90657 – Influenza virus vaccine, split virus, when administered to children 6 -35 months of age, 0.25 mL dosage for intramuscular use (ICD10 code is Z23)

CPT 90658 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, 0.5 mL dosage for intramuscular use (ICD10 code is Z23)

CPT 90660 – Influenza virus vaccine, live, for intranasal use *Note: coverage is limited to ages 2 – 49* (ICD10 code is Z23)

CPT 90661 – Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use. (ICD10 code is Z23) (Age 18 and over)

CPT 90662 – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use (ICD10 code is Z23) (Age 65 and over)

CPT 90670 – Pneumococcal conjugate vaccine, 13 valent. Infants & Children only and Adults aged 65 and over. (Appropriate ICD9 code is V03.82) (Appropriate ICD10 code is Z23)

CPT 90671 – Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use. Subject to the recommendation of the Advisory Committee on Immunization Practices (ACIP) (Appropriate ICD10 code is Z23)

CPT 90672 – (Effective 6/1/2018) Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use (ICD10 code is Z23)

CPT 90673 – Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use. (ICD10 code is Z23) (Age 18 -49)

CPT 90674 – (Effective 1/1/2017) Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

CPT 90677 – Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use. Subject to the recommendation of the Advisory Committee on Immunization Practices (ACIP) (Appropriate ICD10 code is Z23)

CPT 90678 – Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use ; Coverage for 90678 is limited to a single dose for pregnant persons at 32 -36 weeks gestation (Effective October 6, 2023) AND is limited to a single dose for all adults age 75 and older AND

adults age 60 -74 who are at increased risk for severe RSV (Effective August 15, 2024)  
(Appropriate ICD 10 is Z23)

CPT 90679 – Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use; Coverage for 90679 is limited to a single dose for all adults age 75 and older AND adults age 60 -74 who are at increased risk for severe RSV (Effective August 15, 2024)  
(Appropriate ICD 10 is Z23)

CPT 90680 – Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use (ICD10 code is Z23)

CPT 90681 – Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use (ICD10 code is Z23) (Age <1)

CPT 90682 – Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use (Coverage is limited to a single dose in adults age 75 and older AND adults age 60 -74 who are at increased risk for severe RSV, effective 8/15/24). (Appropriate ICD10 code is Z23)

CPT 90683 – Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use; Coverage for 90683 is limited to a single dose for all adults age 75 and older AND adults age 60 -74 who are at increased risk for severe RSV (Effective August 15, 2024) (Appropriate ICD 10 is Z23)

CPT 90684 – Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use; Coverage for 9068 4 is an option for adults age 19 and over who are currently recommended to receive PCV15 or PCV20 (Effective June 27, 2024) (Appropriate ICD 10 is Z23)

CPT 90685 – Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6 -35 months of age, 0.25 mL dosage for intramuscular use. (Appropriate ICD10 code is Z23)

CPT 90686 – Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, 0.5 mL dosage for intramuscular use. (ICD10 code is Z23)

CPT 90687 – Influenza virus vaccine, quadrivalent, split virus, when administered to children 6 - 35 months of age, 0.25 mL dosage for intramuscular use. (ICD10 code is Z23)

CPT 90688 – Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, 0.5 mL dosage for intramuscular use. (ICD10 code is Z23)

CPT 90689 – Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90694 – Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90696 – Diphtheria, tetanus toxoids, acellular pertussis vaccine & polio vaccine, inactivated. Children 4-6 years of age only. (Appropriate ICD10 code is Z23)

CPT 90697 – Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP OMP conjugate vaccine, and hepatitis B vaccine (DTaP IPV Hib HepB), for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90698 – Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza type b, and poliovirus vaccine. Infants & Children Only less than 4 (Appropriate ICD10 code is Z23)

CPT 90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use. (Appropriate ICD10 code is Z23)

CPT 90702 – Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use. (Appropriate ICD10 code is Z23)

CPT 90707 – Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use (Appropriate ICD10 code is Z23)

CPT 90710 – Measles, mumps, rubella, and varicella vaccine (MMRV), live for subcutaneous use (ICD10 code is Z23) (Age <=18 years)

CPT 90713 – Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use (Appropriate ICD10 code is Z23)

CPT 90714 – Tetanus and diphtheria toxoids (Tc) adsorbed preservative free, when administered to individuals 7 years or older, for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90715 – Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90716 – Varicella virus vaccine, live, for subcutaneous use (Appropriate ICD10 code is Z23)

CPT 90723 – Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP -HepB -IPV), for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90732 – Pneumococcal polysaccharide vaccine, 23 -valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use (ICD10 code is Z23)

CPT 90733 – Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use (Appropriate ICD10 code is Z23)

CPT 90734 – Meningococcal conjugate vaccine, serogroups A, C, Y and W -135 (tetravalent), for intramuscular use (ICD10 code is Z23)

CPT 90739 – Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use. Limited to 4 units per lifetime. (ICD10 code is Z23)

CPT 90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use. (Appropriate ICD10 code is Z23) (Age  $\geq 13$  and  $\leq 19$ )

CPT 90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use. (Appropriate ICD10 code is Z23) (Age  $< 19$ )

CPT 90746 – Hepatitis B vaccine, adult dosage, for intramuscular use. Limited to 6 units per lifetime. (Appropriate ICD10 code is Z23).

CPT 90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use. (Appropriate ICD10 code is Z23)

CPT 90748 – Hepatitis B and Hemophilus influenza b vaccine (HepB -Hib), for intramuscular use (Appropriate ICD10 code is Z23)

CPT 90749 – Unlisted Vaccine Toxoid (Appropriate ICD10 code is Z23)

CPT 90750 – Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvant ed, for intramuscular injection (Shingrix). Only for age 50 years and older. (Appropriate ICD 10 code is Z23).

CPT 90756 – Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

CPT 90759 – Hepatitis B vaccine (HepB), 3 -antigen (S, Pre -S1, Pre -S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

CPT 91304 – severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, recombinant spike protein nanoparticle, saponin -based adjuvant, preservative free, 5 mcg/0.5 mL dosage, for intramuscular use (For ages 12 and older) (Appropriate ICD10 code is Z23) (Effective Date 10/3/23)

CPT 91318 – severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, mRNA -LNP, spike protein, 3 mcg/0.2 mL dosage, tris -sucrose formulation, for intramuscular use (Only for 6 mos to 4 yrs) (Appropriate ICD10 code is Z23) (effective date 9/12/2023)

CPT 91319 – severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, mRNA -LNP, spike protein, 10 mcg/0.2 mL dosage, tris -sucrose formulation, for intramuscular use (Only for ages 5 through 11 years) (Appropriate ICD10 code is Z23) (effective date 9/12/2023)

CPT 91320 – Severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, mRNA -LNP, spike protein, 30 mcg/0.3 mL dosage, tris -sucrose formulation, for intramuscular use (For ages 12 years and older) (Appropriate ICD10 code is Z23) (effective date 9/12/2023)

CPT 91321 – Severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, mRNA -LNP, 25 mcg/0.25 mL dosage, for intramuscular use (Only for ages 6 months through 11 years) (Appropriate ICD10 code is Z23) (effective date 9/12/2023)

CPT 91322 – Severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (coronavirus disease [COVID -19]) vaccine, mRNA -LNP, 50 mcg/0.5 mL dosage, for intramuscular use (For ages 12 years and older) (Appropriate ICD10 code is Z23) (effective date 9/12/2023)

CPT 96380 – Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional (effective date 10/6/2023)

CPT 96381 – Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection (effective date 10/6/2023)

HCPCS Q2035 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older (Afluria) (Appropriate ICD10 code is Z23)

HCPCS Q2036 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older (Flulaval) (Appropriate ICD10 code is Z23)

HCPCS Q2037 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older (Fluvirin) (Appropriate ICD10 code is Z23)

HCPCS Q2038 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older (Fluzone) (Appropriate ICD10 code is Z23)

HCPCS Q2039 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older (NOS) (Appropriate ICD10 code is Z23)

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#### **IV. ARKANSAS STATE MANDATED PREVENTIVE SERVICES**

Services addressed in this section apply to members of plans as defined by each individual Arkansas State Mandate.

##### **PROSTATE CANCER SCREENING (Measure 48)**

##### **Arkansas State Mandate**

Act 75 of 2009 requires payment for prostate cancer screening annually for men age 40 and over as recommended by the National Comprehensive Cancer Network effective January 2009.

**CPT/HCPCS Codes**

CPT 84153 – Prostate specific antigen (PSA)

CPT 84154 – Prostate specific antigen (PSA); free

HCPCS G0102 – Prostate cancer screening; digital rectal examination

HCPCS G0103 – Prostate cancer screening; prostate specific antigen test (PSA)

**ICD-10 Code**

Z12.5 – Screen malignant neoplasm -prostate

**Frequency**

Allow once per year.

**COVERAGE OF DIAGNOSTIC EXAMINATIONS FOR BREAST CANCER (Measure 74)**

**Arkansas State Mandate**

Act 553 of 2021 requires payment for breast cancer screening beginning between ages 35 -39 to establish baseline then annually for women age 40 and over or upon recommendation of a woman's physician when the covered person has increased risk defined as: a prior history of breast cancer, a first or second degree family history of breast cancer, positive genetic testing, or other risk factors including dense breast tissue. (This law applies to public school and state employees and governmental self-insured plans. Other self-insured plans are not subject to this law.)

***Breast MRI requires PA managed by Carelon.***

**CPT/HCPCS Codes**

CPT 76641 – Ultrasound, breast, unilateral, real-time w/ image doc, inc. axilla when performed; complete

CPT 76642 – Ultrasound, breast, unilateral, real-time w/ image doc, inc. axilla when performed; limited

CPT 77046 – Magnetic resonance imaging, breast, without contrast material; unilateral

CPT 77047 – Magnetic resonance imaging, breast, without contrast material; bilateral

CPT 77048 – Magnetic resonance imaging, breast, w/o & w/contrast material(s), including computer -aided detection (CAD real -time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral

CPT 77049 – Magnetic resonance imaging, breast, w/o & w/contrast material(s), including computer -aided detection (CAD real -time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

CPT 77063 – Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

CPT 77065 – Diagnostic mammography, including computer -aided detection (CAD) when performed; unilateral

CPT 77066 – Diagnostic mammography, including computer -aided detection (CAD) when performed; bilateral

CPT 77067 – Screening mammography, bilateral (2 -view study of each breast), including computer -aided detection (CAD) when performed

CPT 78800 – Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging

CPT 78801 – Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days

CPT 96374 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/ drug

CPT A9500 – Technetium tc 99m sestamibi diagnostic, per study dose

CPT Q9967 – Low osmolar contrast material, 300 39 mg/ml iodine concentration, per ml

CPT Q9968 – Injection, nonradioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg

CPT S8080 – Scintimammography (radioimmunosintigraphy of the breast), unilateral, including supply of radiopharmaceutical

### **ICD-10 Codes**

Z12.31 – Encounter for screening mammogram for malignant neoplasm of breast

Z12.39 – Encounter for other screening for malignant neoplasm of breast

Z80.3 – Family history of malignant neoplasm of breast

Z85.3 – Personal history of malignant neoplasm of breast

Z92.3 – Personal history of irradiation

N63.0 – Unspecified lump in unspecified breast  
N63.10 – Unspecified lump in the right breast, unspecified quadrant  
N63.11 – Unspecified lump in the right breast, upper outer quadrant  
N63.12 – Unspecified lump in the right breast, upper inner quadrant  
N63.13 – Unspecified lump in the right breast, lower outer quadrant  
N63.14 – Unspecified lump in the right breast, lower inner quadrant  
N63.15 – Unspecified lump in the right breast, overlapping quadrants  
N63.20 – Unspecified lump in the left breast, unspecified quadrant  
N63.21 – Unspecified lump in the left breast, upper outer quadrant  
N63.22 – Unspecified lump in the left breast, upper inner quadrant  
N63.23 – Unspecified lump in the left breast, lower outer quadrant  
N63.24 – Unspecified lump in the left breast, lower inner quadrant  
N63.25 – Unspecified lump in the left breast, overlapping quadrants  
N63.31 – Unspecified lump in axillary tail of the right breast  
N63.32 – Unspecified lump in axillary tail of the left breast  
N63.41 – Unspecified lump in right breast, subareolar  
N63.42 – Unspecified lump in left breast, subareolar  
R92.0 – Mammographic microcalcification found on diagnostic imaging of breast  
R92.1 – Mammographic calcification found on diagnostic imaging of breast  
R92.2 – Inconclusive mammogram (this would include dense breast NOS, inclusive mammography due to dense breast)  
R92.8 – Other abnormal and inconclusive findings on diagnostic imaging of breast

### **Frequency**

Allowed one time between ages 35 -39

Allowed annually for ages 40 and over

## **HEPATITIS C VIRUS SCREENING DURING PREGNANCY (Measure 75)**

### **Arkansas State Mandate**

Act 598 of 2021 requires payment for hepatitis C testing during pregnancy at no cost share.

### **CPT/HCPCS Codes**

CPT 86803 – Hepatitis C, antibody

CPT 87521 – Hepatitis C, amplified probe technique

HCPCS G0472 – Hepatitis C antibody screening for individual at high risk and other covered indication(s)

### **ICD-10 Codes**

Z20.5 – Contact or exposure to other viral diseases

Z57.8 – Personal history of contact with potentially hazardous body fluids

Z72.89 – Other problems related to lifestyle  
Z72.9 – Z73.9 – Unspecified problems related to lifestyle  
Z00.00 – Z00.01 – General Medical Exam  
Z11.59 – Screening for other viral diseases

### Frequency

Allowed 3 times a year for females 11 years of age and older.

## COLORECTAL CANCER SCREENING (Measure 76)

### Arkansas State Mandate

For contracts subject to Arkansas Act 779, the use of MT -DNA + FIT testing (e.g., Cologuard or effective 7/1/2026 Cologuard Plus) is covered for the purpose of colorectal cancer screening in asymptomatic members 45 years old or greater with an average risk of colorectal cancer once every 3 years when no other colorectal cancer screening service (as recommended by the USPSTF) has been provided in the preceding 12 months.

In accordance with Act 779 [Colorectal Cancer Screening] of the Arkansas legislature for all contracts subject to this law: a) coverage of colorectal cancer screening is provided at no cost -share for covered persons aged 45 years or older or b) extended coverage of colorectal cancer screening is provided at no cost -share when covered person meets criteria for high risk.

For contracts subject to Arkansas Act 779, a colonoscopy that is performed as a follow -up to a colorectal cancer screening test, other than a colonoscopy, will be covered at no cost -share when the initial screening test resulted in a positive and the initial screening test is assigned a grade of “A” or a grade of “B” by the United States Preventive Services Task Force.

Colonoscopy remains the recommended test for those with a family history of the disease, for those whose previous screenings have uncovered lesions or polyps, or for those otherwise acknowledged as high risk for colorectal cancer [including but not limited to a personal history of colorectal cancer, a personal history of inflammatory bowel disease such as Crohn’s disease or ulcerative colitis, a personal diagnosis of a genetic condition causing and increased risk of colorectal cancer]. **Specified ICD10 Z12.10 -Z12.12 for 81528, frequency: one every 3 years, no other recommended USPSTF screenings in preceding 12 months**

### CPT/HCPCS Codes

*Appending modifier -PT provides identification of the SURGICAL or ANESTHESIA procedure as a preventive service. Appending modifier -33 to any of the codes in the measure identifies it as a screening procedure.*

CPT 00812 – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

CPT 0464U - Oncology (colorectal) screening, quantitative real time target and signal amplification, methylated DNA markers, including LASS4, LRRRC4 and PPP2R5C, a reference

marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result (effective 7/1/2026)

CPT 45330 – Exploration of colon

CPT 45331 – Sigmoidoscopy

CPT 45332 – Sigmoidoscopy, removal of foreign body

CPT 45333 – Sigmoidoscopy, removal of polyp

CPT 45334 – Sigmoidoscopy, control of bleeding

CPT 45335 – Sigmoidoscopy, directed submucosal injection(s)

CPT 45338 – Sigmoidoscopy, removal of polyp

CPT 45346 – Sigmoidoscopy, ablation of tumors, polyps

CPT 45378 – Colonoscopy, exploration of colon

CPT 45379 – Colonoscopy, removal of foreign body

CPT 45380 – Colonoscopy, biopsy

CPT 45381 – Colonoscopy, directed submucosal injection

CPT 45382 – Colonoscopy, control of bleeding

CPT 45384 – Colonoscopy, removal of polyp by hot forceps

CPT 45385 – Colonoscopy, removal of polyp by snare

CPT 74263 – Computed tomographic (CT) colonography, screening, including image postprocessing

CPT 81528 – MT-DNA +FIT (Cologuard)

CPT 82270 – Occult blood, feces

CPT 82274 – Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1 3 simultaneous determinations

CPT 88305 – Level IV – Pathology

CPT 99152 - Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the

patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

CPT 99153 – Mod sedation provided by same phys or other QHP., req presence of an independent trained observer to assist in monitoring patient's level of consciousness & physiological status; each add'l 15 min intraservice time (List separately in add to code for primary service)

HCPCS G0104 – Colorectal cancer screening; flexible sigmoidoscopy. Cover once every 60 months.

HCPCS G0105 – Colorectal cancer screening; colonoscopy on individual at high risk. Cover once every 10 years.

HCPCS G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. Cover once every 10 yrs.

HCPCS G0328 – Colorectal cancer screening; fecal occult blood test, immunoassay, 1 -3 simultaneous

HCPCS G0500 - Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)

### **ICD-10 Codes**

Z12.10 – Encounter for screening for malignant neoplasm of intestinal tract, unspecified

Z12.11 – Encounter for screening for malignant neoplasm of colon

Z12.12 – Encounter for screening for malignant neoplasm of rectum

Z80.0 – Family history of malignant neoplasm of digestive organs

Z85.038 – Personal history of other malignant neoplasm of large intestine

Z85.048 – Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus

Z86.010 – Personal history of colonic polyps

Z87.19 - Personal history of other diseases of the digestive system

### **Frequency**

There are 5 covered screening services:

- 1) fecal immunochemical testing, annually.
- 2) MT -DNA+FIT once every 3 years with average risk when no other USPSTF recommendation screening services have been provided in preceding 12 months.
- 3) Flexible sigmoidoscopy, every 5 years OR every 10 years when combined with annual FIT.

4) CT colonography every 5 years; 5) flexible colonoscopy every 10 years (average risk) or every 5 years (high risk).

## **V. MISCELLANEOUS PROCEDURES COVERED UNDER WELLNESS, BUT NOT LISTED UNDER PPACA**

**Allowed only once a year in conjunction with an annual wellness exam (Measure 56)**

### **CPT/HCPCS Codes**

CPT 99385 – Initial comprehensive preventive medical exam, 18 -39 years

CPT 99386 – Initial comprehensive preventive medical exam, 40 -64 years

CPT 99387 – Initial comprehensive preventive medical exam, 65 years and older

CPT 99395 – Periodic comprehensive preventive medicine exam, 18 -39 years

CPT 99396 – Periodic comprehensive preventive medicine exam, 40 -64 years

CPT 99397 – Periodic comprehensive preventive medicine exam, 65 years and older

CPT 80050 – General Health Panel (Must include comprehensive metabolic panel, Blood count, complete, thyroid stimulating hormone)

CPT 81000 – Urinalysis by dipstick or tablet reagent, non -automated, with microscopy

CPT 81001 – Urinalysis, by dipstick or tablet reagent, automated, with microscopy

CPT 81002 – Urinalysis by dipstick or tablet reagent, non -automated, without microscopy

CPT 81003 – Urinalysis, by dipstick or tablet reagent, automated, without microscopy

### **ICD-10 Codes**

Z00.00 – Z00.01 – General Medical Examination

### **Frequency**

Allow once per year.